Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 16, 2019	2019_778563_0010	002165-17, 005323-17, 008926-17, 010038-17, 011913-17, 022328-17, 022985-17, 024612-17, 025533-17, 003534-18, 008624-18, 009397-18, 009916-18, 010281-18, 012149-18, 013180-18, 013398-18, 018233-18, 033303-18, 003018-19, 005116-19, 007640-19	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Simcoe
1110 Highway 26 Midhurst ON L9X 1N6

Long-Term Care Home/Foyer de soins de longue durée

Simcoe Manor Home for the Aged
5988 8th Line, Main Street East P.O. Box 100 Beeton ON L0G 1A0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MELANIE NORTHEY (563), AYESHA SARATHY (741), CASSANDRA ALEKSIC (689), KRISTEN MURRAY (731), MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 9, 10 and 11, 2019

The following Critical Incident (CI) intakes were closed during this inspection:

Related to falls prevention
Log #002165-17 / CI #M573-000002-17
Log #005323-17 / CI #M573-000004-17
Log #008926-17 / CI #M573-000007-17
Log #010038-17 / CI #M573-000014-17
Log #024612-17 / CI #M573-000033-17
Log #025533-17 / CI #M573-000035-17
Log #008624-18 / CI #M573-000011-18
Log #009916-18 / CI #M573-000014-18
Log #012149-18 / CI #M573-000020-18
Log #013180-18 / CI #M573-000021-18
Log #013398-18 / CI #M573-000022-18
Log #018233-18 / CI #M573-000027-18
Log #033303-18 / CI #M573-000039-18
Log #003018-19 / CI #M573-000003-19
Log #005116-19 / CI #M573-000006-19

Related to missing residents:
Log #022328-17 / CI #M573-000027-17

Related to the prevention of resident to resident abuse and responsive behaviours:
Log #010281-18 / CI #M573-000016-18

Related to the prevention of staff to resident abuse:
Log #007640-19 / CI #M573-000009-19

Related to medication administration:
Log #011913-17 / CI #M573-000015-17
Log #022985-17 / CI #M573-000029-17
Log #003534-18 / CI #M573-000006-18
Log #009397-18 / CI #M573-000013-18

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Associate Director of Resident Care, Registered Nurses, Registered Practical Nurses, the Beahioural Supports Ontario Lead, Personal Support Workers, a Housekeeper and residents.

The inspector(s) also made observations of residents and care provided. Relevant policies and procedures, as well as the clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The Critical Incident (CI) System Report documented that incorrect medications were administered to a resident. The Unit Registered Practical Nurse (RPN) reported being unfamiliar with the residents and mistook one resident for another resident.

The Medication Incident Final Report documented that the resident was administered four medications not prescribed to them. The electronic Medication Administration Record (eMAR) did not include a physician's order for the four medications administered to the resident.

The Associate Director of Resident Care verified that the RPN administered medications to the resident that were not prescribed for the resident.

The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Critical Incident (CI) System Report documented that the incorrect dose of a medication was administered to a resident. The Registered Practical Nurse (RPN) administered a dose that was higher than what was prescribed.

The electronic Medication Administration Record (eMAR) documented a specific order for a medication. The Associate Director of Resident Care verified that the resident was not administered the medication as prescribed.

The licensee has failed to ensure that a medication was administered to a resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident; and has failed to ensure drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health.

The Critical Incident (CI) System Report documented that incorrect medications were administered to a resident. Three of the four medications administered to the resident were used to treat a specific medical issue. The CI documented a medication incident where the resident had an adverse drug reaction that altered the resident's health status.

The Medication Incident Final Report documented that the resident was administered four medications in a strip package labeled for a different resident. Interventions in response to the medication incident included monitoring a specific vital sign at specific intervals.

The "Medication Incident Description of Error" progress note in Point Click Care (PCC) documented that the specific monitoring was not documented as planned.

The Associate Director of Resident Care (ADRC) verified the resident did not have monitoring documented at the specific intervals recommended. The ADRC also verified that the change in the resident's status was an adverse reaction in response to the incorrect administration of medications used for the specific treatment of a medical issue and there was an incomplete record of the monitoring required to maintain the resident's health. .

The licensee has failed to ensure that the medication incident involving the resident was documented with a record of the immediate actions taken to assess and maintain the resident's health. [s. 135. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to report in writing to the Director setting out the analysis and follow-up action, including the immediate actions that were taken to prevent recurrence, the long-term actions planned to correct the situation when resident #001 had a fall that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition.

The Critical Incident (CI) System report was submitted to the Ministry of Health and Long-Term Care (MOHLTC) and documented that a resident had a fall that resulted in a transfer to hospital and significant change in health condition. The CI report did not include documentation of the analysis and follow-up actions related to the resident's fall. An amended version with the immediate actions taken to prevent recurrence, the interventions that were in place prior to the incident, and the long-term actions planned to correct the situation and prevent recurrence were not submitted to the MOHLTC.

The Director of Care verified the CI report was not amended and to include the analysis and follow-up related to the resident 's fall.

The licensee has failed to make a report in writing to the Director setting out the analysis and follow-up action, including the immediate actions that were taken to prevent recurrence and the long-term actions planned to correct the situation and prevent recurrence related to the resident's fall. [s. 107. (4) 4.]

Issued on this 16th day of April, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.