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
Feb 11, 2019	2019_565647_0003	001322-19	Resident Quality Inspection

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

Trillium Manor Home for the Aged
12 Grace Avenue ORILLIA ON L3V 2K2

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

JENNIFER BROWN (647), SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): February 4 - 8, 2019.

The following Critical Incident System (CIS) report intakes were inspected concurrently with this RQI inspection:
- one related to resident to resident abuse,
- one related to a fall related to injury.

The following complaint was inspected concurrently with this RQI inspection:
- one related to reporting certain matters to the Director, plan of care, and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, made observations in resident home areas, observation of care delivery processes including medication passes, reviewed the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

5 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, procedure, strategy or system, that it was complied with.

Section 114 (2) of the O. Reg. 79/10, states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispending, receipt, storage, administration and destruction and disposal of all drugs used in the home.

During a medication administration observation, Inspector #692 noted seven used containers of an identified medication that did not have a label that indicated the date the container of identified medication was opened or when the container of identified medication was supposed to be discarded.

The home's policy titled "Medication Administration - #MEDI-CL-ONT-045" last reviewed October 2018, required designated medications, to be dated when opened and removed from stock when expired in order to facilitate the identification of an expiration date.

During two separate interviews with Inspector #692, registered staff members #101 and #108 both confirmed that the registered staff were required to label the containers of identified medication when they opened them with the date they were opened and the date they were required to be discarded. During the medication administration observation, registered staff member #101 verified that the seven containers of identified medication were not labelled with the date they were opened, and that they were required to be labelled.

Inspector #692 interviewed the Director of Care (DOC) who confirmed registered staff were provided medication administration education that included the process for opening the identified medication container for administration. The DOC confirmed that the identified medication containers were required to be labeled with the date they were opened in order to know when they were to be discarded. The DOC confirmed that in this instance this did not occur. [s. 8. (1) (b)]

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 to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, procedure, strategy or system, that it is complied with, to be implemented voluntarily.

WN #2: 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. (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 drugs were administered to residents in accordance with directions for use specified by the prescriber.

In a review of the licensee's quarterly medication incident reports, Inspector #692 identified that a medication incident, was reported involving registered staff member #114 who administered to resident #012 a dose of identified medication at a specified time, which had been prescribed by the physician to be administered at a different specified time.

Inspector #692 reviewed the home's policy titled "Medication Pass - #MEDI-CL-003", last reviewed October 2018, which indicated that at the time of medication administration, the registered staff were responsible for applying the rights of medication administration that included:
- The right client/resident,
- The right medication/drug,
- The right dose/amount,
- The right route/method,

- The right time,
- The right reason,
- The right site,
- The right frequency.

In an interview with registered staff member #101, they stated that prior to administering a medication to a resident, the registered staff must ensure that the medication would be provided to the right resident, right medication, right dose, right time, and right route as prescribed by the physician. Registered staff member #101 further stated that these rights were required to be adhered to at all times as indicated in the home's policy under "Medication Pass".

During an interview with registered staff member #108, they confirmed that registered staff member #114 did not administer the medication to resident #012 as prescribed by the resident's physician.

In an interview with the DOC, they verified that on the identified date, a medication incident was submitted by registered staff member #101 due to the incorrect time of the administration of the identified medication to resident #012. The DOC stated that the medication incident report was investigated and analyzed and it was determined that registered staff member #114 did not follow the policy as stated in the medication pass policy as they administered it at the incorrect time. [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 to ensure that drugs are administered to residents in accordance with directions for use specified by the prescriber, 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee informed the Director no later than one business day after an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to a hospital.

Resident #007 was identified as having a fall in the last 30 days from their most recent Resident Assessment Instrument Minimum Data Set (RAI MDS).

During review of the progress notes by Inspector #647, it was documented that on an identified date, the resident had been found in a specific location by a direct care staff member.

Resident #007 had been assessed at that time by registered staff member #106 who indicated that upon assessment, resident #007 had immediately began complaining of pain in a specified location and the registered staff member applied an intervention to the identified area.

Resident #007 continued to complain of pain to the identified area and injury became visible. Resident #007 had been ordered for medical test which confirmed an injury to the specified area.

A further review of the clinical chart indicated that upon resident #007's return, the home completed a significant change assessment and reviewed and revised the plan of care to include the additional care requirements for resident #007.

A review of the Critical Incident System report (CIS) portal indicated that the home had not submitted a CIS report to the Director to indicate that an incident occurred to resident #007 that caused an injury that resulted in a significant change in the resident's health condition.

During an interview with the DOC they indicated that they or their designate are responsible to ensure that all CIS reports are submitted as per the legislative timelines and requirements.

During this interview, the DOC acknowledged that the CIS report as mentioned above was not submitted to the Director as per the required legislation. [s. 107. (3)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that is (ii) secure and locked.

Inspector #692 observed the medication pass and observed that on five occasions during the medication pass, the medication cart was unlocked and left unattended. After preparing a medication for a resident, registered staff member #101 would walk away into another area and leave the medication cart unlocked where they were unable to observe the medication cart.

In a review of the home's policy titled, "Medication Pass - #MEDI-CL-003", last reviewed October 2018, the policy indicated the registered staff were not to leave the medication cart unattended at any time unless all medications were securely locked.

During an interview with registered staff member #101, they confirmed that they did walk away and leave the medication cart unlocked on five occasions during their medication pass. Registered staff member #101 confirmed that when they walked away from the cart and were in another room they did not have the medication cart within their line of vision at all times.

During an interview with registered staff member #108, they stated that the registered staff were to lock the medication cart when they were not able to "have their eyes on the cart at all times". Registered staff member #108 confirmed that registered staff were provided training on medication administration, that included ensuring the medication cart was locked when they are not in attendance.

In an interview with the DOC, they confirmed that it is an expectation that the medication cart be locked at all times when registered staff were not in attendance of the cart. [s. 129. (1) (a)]

WN #5: 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 reported to the resident's Substitute Decision Maker (SDM).

In a review of the licensee's quarterly medication incident reports, Inspector #692 identified that on an identified date, a medication incident, was reported involving registered staff member #114 who administered to resident #012 a dose of identified medication at a specified time, which had been prescribed by the physician to be administered at another specified time.

Inspector #692 reviewed resident #012's electronic progress notes for the above mentioned medication incident and failed to identify documentation which indicated that the resident's SDM had been informed of the incident.

Inspector #692 reviewed the home's policy titled "Medication Incident Management - #MED-CL-ONT-022", last reviewed October 2018, which indicated that the resident's SDM was to be notified of the incident that reached the resident.

Inspector #692 interviewed registered staff member #101 who stated that they did not notify resident #012's SDM when they identified that registered staff member #114 had administered resident #012's medication at the incorrect time. Registered staff member #101 confirmed that the residents' SDM was to be notified of all medication incidents at the time of the incident.

During an interview with registered staff member #108, they stated all SDMs were to be notified of all medication incidents that reach the resident at the time of the incident.

Inspector #692 interviewed the DOC who indicated that for all medication incidents that reaches the resident, the residents' SDM was to be notified at the time of the incident. Upon reviewing medication incident, the DOC further stated that there was not any documentation to substantiate that resident #012's SDM had been notified of the medication incident, and that they should have been. [s. 135. (1)]

Issued on this 11th day of February, 2019

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

Original report signed by the inspector.