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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 17, 2017	2017_563670_0024	022537-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

ILER LODGE
111 ILER AVENUE ESSEX ON N8M 1T6

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

DEBRA CHURCHER (670), ADAM CANN (634), ANDREA DIMENNA (669)

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): October 2, 3, 4, 5, and 6, 2017.

The following intakes were completed within the RQI:

Log #020166-17 Complaint related to staffing.
Log #016646-17 Complaint related to staffing.
Log #017507-17 Complaint related to staffing.
Log #020651-17 Complaint related to staffing.
Log #020659-17 Complaint related to staffing.
Log #016737-17 Complaint related to staffing.
Log #020975-17 Complaint related to staffing.
Log #021275-17 Complaint related to staffing.
Log #021324-17 Complaint related to staffing.
Log #012443-17 Complaint related to staffing and provision of equipment.
Log #018221-17 Complaint related to staffing and personal care.
Log #006392-17 CIS #2129-000018-17 related to a fall with injury.
Log #000470-17 CIS #2129-000003-17 related to a fall with injury.
Log #026706-16 CIS #2129-000026-16 related to a fall with injury.

During the course of the inspection, the inspector(s) spoke with forty + residents, the representative of the Family Council, the representative of the Residents' Council, the Director of Care, the Business Office Manager, the Program Manager, the Nutrition Manager, the Environmental Services Manager, The Regional Manager of Clinical Services, one Registered Nurse, three Registered Practical Nurses and sixteen Personal Support Workers.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Sufficient Staffing

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

- **7 WN(s)**
- **7 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	Legendé 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

The home submitted a Critical Incident System report to the Ministry of Health and Long-Term Care on a specific date, related to an incident in the home resulting in an injury to a resident, on a specific date.

A review of a specific resident's chart revealed that the resident experienced an incident in the home resulting in a specific injury. The clinical record also stated that the resident had experienced multiple similar incidents.

The resident's care plan, last completed on a specific date, was reviewed and included a specific focus that the resident was at high-risk for specific incidents. This focus included several specific interventions. Further review of the plan of care under a separate specific focus, contained specific interventions which contradicted the previous interventions for the previous specific focus.

The Inspector observed specific interventions in place for the resident.

Two Personal Support Workers (PSW's) were interviewed and explained that specific interventions for the resident were located in the resident's Point Of Care (POC) .

A Registered Practical Nurse (RPN) and Registered Nurse (RN) were interviewed and said that all specific interventions for the resident were documented in the resident's care plan.

A PSW was interviewed and stated that if they were unsure of interventions required for a resident, they would refer to the resident's care plan.

A PSW was interviewed and said that if they were unsure whether or not a resident required specific interventions, they would look in the POC kardex.

A PSW was interviewed and was unsure of the specific interventions for the resident.

An RPN was interviewed and review the plan of care with the Inspector and acknowledged that the resident's care plan was not clear in providing staff direction

related to specific interventions.

The Director of Care (DOC) was interviewed and acknowledged that the conflicting interventions in the resident's care plan was not up-to-date would cause confusion for staff.

The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to a specific resident.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated. The home has a history of one or more unrelated non-compliance in the last three years. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff

of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Review of the Registered Nurse (RN) schedules for three specific months stated that the home did not have an RN in the building on the evening shift for nine shifts during the time frame reviewed, and no RN in the building on the night shift for fifteen shifts during the time frame reviewed, for a total of twenty four shifts or 8.7 percent of RN shifts not being covered.

The home's staffing plan, alternate staffing contingency plans section, stated "List all possible strategies that are to be used to replace the vacant shift and the strategies that are to be implemented to provide resident care. For example:

-Initiate Call in Roster as per collective agreement, if applicable

-Extend Shifts

-Reassign work assignments

-Utilize Agency"

Director of Care (DOC) acknowledged that there were twenty four shifts not covered by a RN during a specific time frame. The DOC stated that they had a RN shortage due to unexpected illness and resignations and that they had attempted to cover the shifts with their RN staffing pool and had offered the staff overtime and other scheduling incentives. If the shifts could not be covered they brought in an extra Registered Practical Nurse (RPN) and the DOC and Administrator who are both RN's would be on call. DOC stated that they had not attempted to procure RN coverage from outside sources.

The Business Manager (BM) stated that the home had attempted to cover any RN shortages with their current RN staffing complement and had offered over time for the shifts, however there were some that they could not fill. BM stated that the home did not attempt to utilize any outside staffing during the RN shortage.

The licensee has failed to ensure that there was at least one registered nurse on duty at all times.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated. The home has a history of one or more unrelated non-compliance in the last three years. [s. 8. (3)]

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 ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During the inspection a specific resident was observed with a specific intervention in place.

Record review was completed of the resident's care plan which stated a specific intervention that was classed as a Personal Assistive Device (PASD) and a specific rationale for the intervention.

Record review of the assessments tab in Point Click Care and review of progress notes did not show an assessment related to the use of the specific intervention and equipment.

Record review of the Revera Personal Assistive Services Device (PASD) decision tree stated that if a PASD that has the effect of the PASD on the resident has specific effects on a resident it is not considered a PASD but is considered a specific intervention that would require quarterly assessments.

In an interview with Personal Support Worker (PSW), they stated that the intervention does have the potential to have specific effects on the resident.

In an interview with Resident Assessment Instrument coordinator, they stated that the specific intervention would limit the residents movement.

In an interview with the Director of Care (DOC), the DOC stated that the intervention does limit and inhibit the resident's movement. The DOC said that the intervention does limit or inhibit movement and an assessment for its use should have been conducted but was not.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was isolated. The home has a history of one or more unrelated non-compliance in the last three years. [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 o 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 (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who was incontinent received an assessment that included identification of: causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

During stage one of the RQI, generated from Minimum Data Set (MDS) information, a

resident was identified as having a condition and was also identified as a low risk for the condition.

The resident’s MDS quarterly assessment, dated for a specific date, stated the resident required specific interventions, and had specific symptoms. The MDS assessment also stated that specific equipment was used for the resident, and that the resident had no change in their specific condition.

The resident's Point of Care Task for the specific condition was reviewed for the period for a specific time frame, and showed that the resident experienced symptoms on multiple occasions during the specific time frame.

The resident's electronic chart was reviewed and there was a specific assessment dated for a specific date, was noted in Point Click Care (PCC) but was incomplete as there was no information in the assessment. No further specific assessments were noted in the resident's electronic chart.

Two Personal Support Workers (PSW's) were interviewed and shared that the resident frequently experienced specific symptoms.

A Registered Practical Nurse (RPN) was interviewed and stated that specific assessments were done by PSW staff and documented in PCC.

A Registered Nurse (RN) was interviewed and explained that specific assessments were done on admission for every resident, quarterly, and when required. The RN said that specific assessments were completed using a specific tool in PCC. The RN reviewed the resident's electronic chart and acknowledged that the resident had an open specific assessment that was not completed on a specific date. The RN said that this assessment should have been completed on admission, and that resident should have had a the specific assessment completed.

The Director of Care (DOC) was interviewed, and acknowledged that there was no specific assessment completed for the resident.

The licensee failed to ensure that the resident who was incontinent received an assessment. [s. 51. (2) (a)]

2. The licensee has failed to ensure that a resident who is incontinent had an individualized plan of care to promote and manage bowel and bladder continence based on the assessment.

Review of a specific resident's Minimum Data Set (MDS) dated for a specific date, showed that the resident had been frequently experiencing a condition. Review of the resident's care plan in Point Click Care showed that resident was experiencing the condition daily/less than daily.

Review of the resident's assessments in Point Click Care revealed a specific assessment which was opened but the form was not completed.

In an interview with a Registered Nurse (RN), the RN stated that a specific assessment is to be completed on admission, quarterly, and when required.

In an interview with Director of Care (DOC), they stated that each resident who has a specific condition should receive a specific assessment. The DOC stated that the home had not completed the specific assessment for the resident that had a specific condition.

The severity of this non-compliance was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern. The home has a history of one or more unrelated non-compliance in the last three years. [s. 51. (2) (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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents’ Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents’ Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents’ Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

During the home’s Resident Quality Inspection (RQI), representatives of Residents’ Council were interviewed as part of the mandatory task and identified that the home did not provide written responses for concerns brought forward at Council meetings.

The home's policy, "LTC- Residents' Council (Index CARE16-O20.01)”, effective August 31, 2016, was reviewed and stated that suggestions, concerns, and complaints from the Residents' Council would be documented on the Residents' Council Concern Form. The policy continued that all items on the form would be investigated and responded to in

writing by the Home's Executive Director within ten days.

A binder was reviewed which contained Residents' Council Meeting Minutes for eleven months excluding one month that was not available, and any Residents' Council Concern Forms completed during that time period.

The Residents' Council Meeting Minutes for a specific month stated that new concerns had been brought forward to department managers. The Residents' Council Meeting Minutes for a specific month stated that there was an additional concern brought forward and that a concern form would be sent to the environmental manager.

Two Residents' Council Concern Forms were included in the Residents' Council Meeting Minutes binder:
a) dated for a specific date, related to a specific concern, and included a specific follow up, dated for a specific date, that the concern was responded to verbally at the Residents' Council meeting on a specific date.
b) dated for a specific date, related to a specific concern that included the previous Director of Care's response dated for a specific date.

The Residents' Council Meeting Minutes binder did not contain a concern form related to one of the specific concerns.

The Residents' Council Meeting Minutes were reviewed and showed that three specific residents all attended meetings regularly. A specific resident was interviewed and stated that Residents' Council did not receive responses in writing from the home addressing their concerns. A specific resident was interviewed and was unable to recall any written responses from the home related to their concerns, but stated that the home responded verbally at meetings. A specific resident was interviewed and shared that they had never seen responses to concerns in writing, but that their concerns were discussed at meetings.

The Recreation Manager (RM) was interviewed and acknowledged that they were the assistant to the Residents' Council who attended meetings and wrote the minutes. The RM explained that at every Residents' Council meeting, the residents were asked if there were concerns in each department. The RM continued that when a concern was raised, the RM wrote a concern form and forwarded it to the manager of the department related to the concern, who then had 10 days to respond to the concern in writing. The RM shared that sometimes managers responded, and other times they did not. The RM said

that if a manager did not respond to the concern form, they would be invited to the next Residents’ Council meeting to discuss the concern with the residents and ensure Council was satisfied with the resolution. The RM recalled the concern brought up in the a specifc meeting related to a specific concern. The RM stated that they completed a concern form and sent it to Environmental Services Manager (ESM), who never returned the form. The RM stated that the ESM provided a verbal response to the concern, which the RM then brought to the next Residents’ Council meeting. The RM acknowledged that the specific concern was not responded to in the correct manner.

The Nutrition Manager (NM) was interviewed and stated that they attended all Residents’ Council meetings along with the RM and conducted the Residents’ Food Committee within the Council meetings. The NM explained that the RM reviewed concerns or complaints at meetings and that concerns brought up during Council meetings were written on a concern or suggestion form by the RM. The NM continued that concern forms were forwarded to the appropriate manager, who then had 10 business days to respond to the concern in writing. The NM said that all concerns were documented in meeting minutes, but that a concern form would only be completed if a response was unable to be provided during the meeting. The NM stated that recent concerns brought up during Council meetings included two specific concerns. The NM acknowledged that no concern form was completed for either of these issues. The NM reviewed the concern form dated for a specific date, related to two specific concerns. The NM recalled these concerns and acknowledged that their response was written on a specific date, and reviewed verbally the same day at the Council meeting. The NM stated that they did not respond in writing within the required 10 days. The NM recalled the a specific concern raised on a specific date at a Residents' Council meeting, and acknowledged that there was no concern form located in the Residents’ Council Meeting Minutes binder related to the specific concern.

The ESM was interviewed and stated that they recalled the specific concern. The ESM acknowledged that they did receive a concern form about the issue, but was unable to recall what they did with the form. The ESM stated that they may have given the form back to the RM, or they may still have the form in their office. The ESM searched their office and was unable to find the concern form.

The DOC was interviewed and stated that concerns from Residents’ Council meetings were brought to the management’s attention verbally by the RM and that all responses to concerns were provided to Residents’ Council verbally.

The licensee has failed to ensure that the licensee responded in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

The severity of this non-compliance was determined to be a level 1 as there was minimum risk. The scope of this issue was a pattern. The home has a history of one or more unrelated non-compliance in the last three years. [s. 57. (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 if the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that they respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

Review of the Family Council minutes and responses stated that there was a Family Council meeting on four specific dates.

Responses to the Family Council were dated for two specific dates.

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The home’s policy titled LTC-Family Council Operation Care 16-O.20.02, last reviewed July 31, 2016 stated “If the Family council has brought forward concerns or recommendations, the Executive Director will respond to the Family Council in writing, within ten days of receiving the concern.”

Family Council representative stated that there were times that it was over the 10 days for the home to respond to the Family Council and sometimes well over a week late.

The Recreation Manager stated that the responses dated for a specific date, responded to the previous months meeting, and the responses dated for a specific date, responded to the previous months meeting. The Inspector and the Recreation Manager were unable to locate any response from the licensee related to the meeting for a specific month. The Recreation Manager acknowledged that the response had not been completed. The Recreation Manager stated that the Family Council gives them the minutes from the meeting within five days of the meeting and they then take those minutes to the next management meeting to review with the management team. Appropriate members of the management team give their responses and the Recreation Manager then types the responses and gives them to the Family Council just prior to their next meeting. The Recreation Manager acknowledged that this process was not completed within 10 days of receiving the Family Council minutes/concerns/questions/advice and that the response was given to the Family Council just prior to the next meeting.

The Director of Care stated that it would be the expectation of the home that they would respond to Family Council within 10 days of receiving the Family Council meeting minutes.

The severity of this non-compliance was determined to be a level 1 as there was minimum risk. The scope of this issue was widespread. The home has a history of one or more unrelated non-compliance in the last three years. [s. 60. (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 if the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing, to be implemented voluntarily.

WN #7: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to a written record was kept of everything required under clauses (a) and (b) of r. 135. (2).

The Inspector reviewed specific Medication Incident Reports (MIR).

Interview was completed with Director of Care (DOC) on a specific date who stated that these medication incidents were reviewed and discussed at a management meeting. The DOC could not produce a written record of a full review and analysis of the medication incident involving a specific resident. The DOC was not able to determine by the documentation of the medication incident, whether the Registered Practical Nurse (RPN) had completed a specific action. The DOC had to check the Electronic Medication Administration Record (EMAR) to determine who the RPN was that was involved in the medication incident as it was not included in any documentation of the medication incident. The DOC stated they would expect to see details of the role of the RPN in the medication incident on the review and analysis of the medication incident but was unable to produce this documentation.

Review of a Medication Incident Report (MIR) revealed a specific medication had a change in orders and the orders had not been processed.

Interview was completed with a Registered Nurse (RN) on a specific date, who stated they did not remember the incident. The RN stated they could not recall anything about the incident even though they were named the supervisor notified on the medication incident form. The RN stated they had completed a hard copy medication incident report which would have more information.

Interview was completed with the Director of Care (DOC) on a specific date, who stated that they had looked for the hard copy medication incident reports but they could not be located. The DOC stated that they have no further documentation which showed a review and analysis, or corrective action taken for the specific medication incident. The only documentation provided by the home was the electronic form of the medication incident. The DOC stated that the medication incident was both a pharmacy and a nursing incident. The DOC stated that no place on the documentation of the medication incident did it refer to the medication incident being a nursing incident. The DOC stated that the documentation of the medication incident did not show that a full review and analysis of the medication incident was completed.

The licensee has failed to ensure that a written record was kept of everything required under clauses (a) and (b) of r. 135. (2). [s. 135. (2)]

2. The licensee has failed to ensure that a quarterly review was undertaken of all

medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Review of the home's medication incidents for the second quarter revealed five medication incidents had occurred.

Review of the Professional Advisory Committee (PAC) agenda dated for a specific date, showed three pharmacy related medication incidents had been reviewed. The agenda stated there were five medication incidents but only showed evidence of review for the three pharmacy related incidents.

In an interview with the Director of Care (DOC) on a specific date, they stated that a quarterly review of medication incidents should occur at their Professional Advisory Committee (PAC) meetings. The DOC stated that a specific Medication Incident Report had not been reviewed at the PAC meeting on a specific date. The DOC stated that the incident was mentioned in the meeting but was not reviewed and analyzed.

The severity of this non-compliance was determined to be a level one as there was minimal risk. The scope of this issue was a pattern. The home has a history of one or more unrelated non-compliance in the last three years. [s. 135. (3)]

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,
1) (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b)
2) (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; (b) any changes and improvements identified in the review are implemented; and (c) a written record is kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

Issued on this 24th day of November, 2017

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

Original report signed by the inspector.