Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Sep 18, 2020	2020_760758_0012	015243-20	Critical Incident System

Licensee/Titulaire de permis

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

Villa Forum
175 Forum Drive MISSISSAUGA ON L4Z 4E5

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

DANIELA LUPU (758), NUZHAT UDDIN (532)

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): August 10-14 and 17-20, 2020.

The following intakes were completed in this Critical Incident inspection:

Log #015243-20, related to medication administration.

PLEASE NOTE: This Critical Incident inspection was conducted concurrently with Complaint inspection #2020_760758_0011.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Directors of Care (Co-DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), and residents.

The inspector(s) reviewed relevant residents' clinical records, plans of care, pertinent policies and procedures, the home's investigative records, and observed resident and staff interactions.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols developed for the medication management system were implemented in accordance with evidence-based practices and, if there were none, in accordance with the prevailing practices.

In accordance with O. Reg. 79/10 114 (1) and in reference to 114 (2) the licensee was required to ensure that written policies and protocols for the medication management system ensured the accurate administration of all drugs used in the home.

According to the home's policy titled Medication Administration, last reviewed December, 2017, all medications and treatments were to be labelled and dispensed in accordance with the provincial and federal legislation.

Medications were to be administered only from the properly labelled containers/pouches. Registered Staff were required to follow Professional College practice directives and guidelines with respect to Medication Administration.

The Registered Staff were required to locate and identify the resident and check the name, route, dosage, time and drug, before the medication administration. Labels on drugs were not to be changed by the staff.

Incorrect instructions on the label of the medication for resident #006 were noted. The administration instructions were missing from the label of the medication for resident #007.

i) Resident #006's physician's order indicated to administer a specified amount of the medication.

Resident #006’s medication label instructions indicated to administer a different amount than the physician's order.

Registered staff #105 acknowledged that the instructions on the medication label for resident #006 were incorrect.

Review of resident #006's medication supply found that the medication package also contained the label with the incorrect administration instructions.

ii) Resident #007’s physician’s order indicated to increase the medication dosage.

Resident #007’s medication had a label with the resident’s name and location and the name of the medication, but it did not contain any instructions for administration.

Review of resident #007's medication supply found that the label contained incorrect administration instructions, indicating to administer a different dosage than the physician's order.

Registered staff #119 said that resident #007’s medication label should have contained the instructions for administration and noted the incorrect administration instructions on the medication package.

Co Director of Care (Co-DOC) #112 said that they were not aware of the incorrect or missing medication administration instructions for residents #007 and #006. They said that they informed the pharmacy provider about the issue in the same day.

The licensee has failed to ensure that written policies and protocols developed for the medication management system were implemented for residents #006 and #007 in accordance with evidence-based practices and, if there were none, in accordance with the prevailing practices. [s. 114. (3) (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 to ensure that written policies and protocols are developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with the prevailing practices, 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 the directions for use specified by the prescriber.

A Critical Incident (CI) was submitted to Ministry of Long-Term Care (MLTC), related to incorrect medication administration to resident #007, resulting in the resident's transfer to the hospital.

The Medication Administration Record (MAR) documented that the resident had an order to administer a specified medication.

Physician's order on an identified date, stated to give a different medication one time only.

Resident #007 received the incorrect medication. Nurse Practitioner (NP) #118 was notified and an order was received to monitor and transfer the resident to the hospital.

Registered Practical Nurse (RPN) #117 said that they administered the wrong medication to the resident.

Co-DOC #111 stated that the medication prescribed for one time only should have been removed and discarded after use. However, the process was not followed and incorrect medication was administered to the resident.

The licensee has failed to ensure that drugs were administered to resident #007 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 to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 23rd day of September, 2020

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

Original report signed by the inspector.