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 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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jul 11, 2017 | 2017_597655_0012 | 009565-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

DEEM MANAGEMENT LIMITED
2 QUEEN STREET EAST SUITE 1500 TORONTO ON M5C 3G5

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

WELLINGTON HOUSE NURSING HOME
990 EDWARD STREET NORTH P.O. BOX1510 PRESCOTT ON K0E 1T0

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

MICHELLE EDWARDS (655), DARLENE MURPHY (103)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): June 26, 27, 28, 29, and 30, 2017.**

**During the course of the inspection, the inspector(s) spoke with residents and families, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Physiotherapist Aide, the Resident Assessment Instrument (RAI) Coordinator, and the Director of Care (DOC)/Administrator.**

**During the inspection, the Inspector also observed the provision of resident care and services; and reviewed resident health care records, staff training records, Professional Advisory Committee (PAC) meeting minutes, and documentation related to medication incidents.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**
**Skin and Wound Care**

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

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (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.

The home's medication incident reports, covering a period of six months, were reviewed.

According to a medication incident report, resident #017 exhibited specified symptoms on a specified date. The registered staff notified the physician who ordered a specified medication to be given stat. In error, the RPN administered the incorrect dose to resident #017.

Resident #021 had a physician's order to receive a specified medication at a specified frequency each day. On a specified date, the registered staff failed to administer a dose of the specified medication. The error was discovered several hours later.

Resident #007 had a physician's order for a specified medication to be administered daily. On a specified date, the registered staff failed to administer the medication as prescribed. The error was discovered the following day when the medication was found in the resident's medication strip packaging.

On a specified date, the physician discontinued resident #014's order for a specified medication. Three days later, it was discovered that resident #014 had received the specified medication on two specified dates, after the order to discontinue the same specified medication. The medication card for the specified medication was removed from the medication cart and placed in the drug destruction box upon the discovery of the error.

On a specified date, the registered staff failed to administer three specified medications to resident #012. The error was discovered several hours later on the same day.

All of the above noted resident health care records were reviewed and there was no evidence of any adverse effects to the residents as a result of the errors.

The licensee failed to ensure that drugs were administered to residents (#'s 017, 021, 007, 014, and 012) 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 are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) a weight monitoring system to measure and record with respect to each resident,**
**(i) weight on admission and monthly thereafter, and**
**(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure resident heights were recorded on an annual basis.

During this inspection, it was noted that ten out of the twenty residents reviewed did not have a height recorded on an annual basis. Seven out of ten of these identified residents had heights that were last recorded in 2014 and the remaining three residents had heights last recorded in 2015.

A yearly height is required to ensure the resident's body mass index can be accurately calculated. [s. 68. (2) (e) (ii)]

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**WN #3: 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).**

**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 ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident's health and that every medication incident involving a resident is 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.

On June 28, 2017, the inspector requested a copy of all documented medication incidents for a period of six months. A total of six medication incidents were provided by the Director of Care (DOC) to the inspector.

The inspector reviewed all of the medication incidents and identified that five of the six incidents were at the level of administration and involved a high risk medication. Four of the six incidents failed to meet the required legislated requirements for medication incidents.

On June 29, 2017, the DOC was interviewed in regards to the home's process for the management of medication incidents. The DOC indicated that the family and physician are notified of all medication incidents, and that the home's prescribing physician was also the Medical Director. The four identified medication incidents were reviewed with the DOC.

The first medication incident was identified as a dose omission and involved resident #021 whereby on a specified date, the resident did not receive one of the prescribed doses of a specified medication. The error was discovered the following day. The medication incident report indicated that neither the resident, the resident's substitute decision maker, nor the physician were notified of the error. In addition, there was no supporting documentation to reflect the immediate actions taken to assess the resident.

The second medication incident was identified as an extra dose being administered and involved resident #014. The resident received one additional dose of a specified medication on two consecutive days (a total of two additional doses) following the discontinuation of the specified medication by the prescribing physician. Upon discovery of the error, the medication card for the specified medication was placed in the drug destruction box. Notifications were made to both the family and the physician, but there was no documentation to reflect the immediate actions taken to assess the resident upon the discovery of the error.

The third medication incident was identified as a dose omission and involved resident #007 whereby the resident did not receive the prescribed dose of a specified medication on a specified date, which was prescribed for the management of the resident's specific medical condition. The error was discovered the following day when the medication was found to still be in the medication strip packaging from the previous day. Notifications were made to both the family and the physician, but there was no documentation to reflect the immediate actions taken to assess the resident following the discovery of the error.

The fourth medication incident was identified as a dose omission and involved resident #012 whereby the resident did not receive three specified prescribed medications on a specified date. The error was discovered several hours later on the same day. The appropriate notifications were made; however, there was no documentation to reflect the immediate actions taken to assess the resident.

The licensee has failed to ensure that every medication incident involving a resident is documented along with the immediate actions to assess and maintain the resident's health and that notifications are done in accordance with the legislation. [s. 135. (1)]

2. The licensee has failed to ensure that a quarterly review is undertaken of all medications 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 including any changes and improvements identified in the review that are implemented and a written record of the above.

The DOC was interviewed in regards to the home's process for reviewing all medication incidents and adverse drug reactions on a quarterly basis. The DOC indicated to the Inspector that medication incidents are reviewed during the Professional Advisory Committee (PAC) meetings that are held every three months. The inspector was provided with the 2017 PAC meeting minutes for review.

The inspector noted that on February 8, 2017, and May 10, 2017, PAC meetings were held. A document titled, "Clinical Consultant Pharmacist Quarterly Report" was included in both of the meeting minutes and each report contained a number of statistics relevant to the medication management of the residents. The document also included the statistics related to the medication incidents that had been reported over the previous quarter. The written minutes taken during the two PAC meetings were reviewed and

there was no documentation to reflect the review or discussion of the medication incidents.

The DOC was interviewed and reviewed the meeting minutes of the two PAC meetings that had been held in 2017. The DOC indicated to the Inspector that each individual medication incident is not discussed at the PAC meetings; and that the medication incidents are only touched upon briefly. The DOC agreed that, at this time, the home is not completing a quarterly review of all medication incidents in order to reduce and prevent medication incidents. [s. 135. (3)]

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**Issued on this 11th day of July, 2017**

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

**Original report signed by the inspector.**