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
May 22, 2020	2020_784762_0010	001466-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of York
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

York Region Newmarket Health Centre
194 Eagle Street NEWMARKET ON L3Y 1J6

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

MOSES NEELAM (762)

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): March 6, 9 and 10, 2020

The following log was included during this inspection:
- Log related to a an incident leading to an adverse event and transfer to the hospital

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPN), Assistant Director of Care (ADOC), and Residents.

During the course of this inspection, the Inspector(s) toured specific resident rooms, resident common areas, observed medication passes, interviewed staff and reviewed clinical records

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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).

Findings/Faits saillants :

1. The licensee 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

A Critical Incident Report (CIR) was submitted to the Ministry of Long-Term Care. The CIR surmised that resident #001 was taken to the hospital due to an adverse reaction as a result of an incident that occurred and returned to the Long-Term Care Home (LTCH) on specified date.

A review of the incident form, indicated, medications were given to resident #001 instead of resident #002. The incident form described, a Student Nurse (SN)#104 was being supervised by RPN #103 when dispensing the medication and walking towards resident #001. During this time, the RPN #103 became distracted with another resident and upon return SN #104 stated they had given the medication to the wrong resident.

In an interview RPN #103 stated, the SN #104 was supervised by RPN #103 when dispensing the medication and when the SN #104 was walking in the direction of the resident #001. Furthermore, as the student was walking towards the resident #001, another resident had called RPN #103, when attending to that resident, the SN #104 had given the medication to the wrong resident.

In an interview Assistant Director of Care (ADOC) #105, reviewed the incident report and confirmed that resident #001 was administered medication that had not been prescribed to them. The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident,, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A Critical Incident Report (CIR) submitted to the Ministry of Long-Term Care. The CIR surmised that resident #001 was taken to the hospital due to an adverse reaction as a result of an incident, as a result resident #002 received their medication at a later time in the day on specified date.

A review of resident #002 chart indicated, resident did not receive the specified medication as ordered by the physician.
A review of the incident form, indicated, resident #002's medication were given to resident #001, as a result pharmacy had asked RPN #103 to give resident #002 medication from the evening medication pass and that the medication would be replenished. However, certain medications were not available. A review of resident #002's medication orders did not indicate that the unavailable medication were to be held.

In an interview RPN #103 stated, the unavailable medication were not sent, as the pharmacy provider stated the resident can miss the dose. Furthermore, in the interview RPN #103, stated the physician may have been aware of the holding of the medication, but an order was not provided to hold the unavailable medication.

In an interview ADOC #105, reviewed the above documents and confirmed that resident #002 was not administered the unavailable medication as per the plan of care. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

Issued on this 9th day of June, 2020

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

Original report signed by the inspector.