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
Jun 4, 2020	2020_575214_0012	024095-19, 003704-20, 006367-20	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

The Woodlands of Sunset
920 Pelham Street WELLAND ON L3C 1Y5

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

CATHY FEDIASH (214)

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): May 26, 27, 28, 2020, as an off-site inspection.

Please note: The following intakes were completed during this Critical Incident System (CIS) inspection:

-Log #024095-19- related to medication management.

-Log #003704-20- related to medication management.

-Log #006367-20- related to medication management.

During the course of the inspection, the inspector(s) spoke with the Administrator; Director of Resident Care (DRC); Associate Director of Resident Care (ADRC).

During the course of the inspection, the inspector(s) reviewed the Critical Incident System (CIS) report; resident clinical records; home's investigative notes; medication incidents; policy and procedures; staff training records and analysis of medication incident(s) documentation.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 ensue that a medication incident involving resident #001 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and reported to the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident.

A review of CIS #M617-000026-19, indicated that on an identified date and time, a missing dose of a specified drug for resident #001, had been identified. Registered staff #100, had administered medications to the resident during this shift.

A review of a specified record on this date, prior to the start of the shift indicated the quantity of this drug on hand, was accurate. A written statement by Registered staff #102 indicated that upon becoming aware of the missing drug, no other drug discrepancies were noted; all other drugs of this nature were accounted for and all drug bins were checked. The staff's statement indicated that only one other resident was prescribed the same drug and dose and that the count of their drug was accurate.

A review of registered staff #101 and #102's written statements; the CIS and an interview with the DRC and ADRC, indicated that resident #001's specified drug had a dose punched out of one blister card on an identified day and another dose had been punched out of a second blister card for a different identified day.

A review of resident #001's prescriber order form, indicated that approximately one week prior to this CIS, this identified drug prescription had been changed with instruction to

administer at a different time. The changed orders for this drug were clarified the following day. During an interview, the DRC and ADRC indicated the pharmacy delivered this drug, with the new time change, in two blister cards, both with the same prescription number. One card contained one dose for a specified day of administration and the second card contained the doses for the upcoming week. The DRC and ADRC indicated that the scheduled dose on the day the drug order was clarified was administered from the blister pack of the prior order, which was the same dose and administered at the new prescribed time. When the new blister cards came from pharmacy, they were accounted for and placed in the medication cart. The DRC and ADRC indicated that on the date and time, specified in the CIS, it was identified that one dose of this drug had been removed from the blister card that contained only the single dose and one tablet had been removed from the blister card that contained multiple doses. The DRC and ADRC indicated it was possible two doses had been administered to resident #001; however, registered staff #100, could not recall administering a second dose of this drug.

A specified form was reviewed and identified an area for staff to document whom this incident had been reported to. The area to document notifying the Medical Director was blank and no signature or date for the Medical Director/physician was noted on the bottom of this form.

A review of specified documentation for resident #001, for a period of six identified dates, indicated the immediate actions taken to assess and maintain the resident’s health had not been documented for a period of 16 hours after becoming aware of this incident. No documentation was observed indicating the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident, had been notified of this medication incident. This was confirmed by the DRC and ADRC, during an interview. [s. 135. (1)]

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Issued on this 5th day of June, 2020

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

Original report signed by the inspector.