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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 5, 2014	2014_265526_0015	H-000724-13, H-000704-14	Critical Incident System

Licensee/Titulaire de permis

UNITED MENNONITE HOME FOR THE AGED
4024 Twenty-Third Street, Vineland, ON, L0R-2C0

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

UNITED MENNONITE HOME
4024 Twenty-Third Street, Vineland, ON, L0R-2C0

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

THERESA MCMILLAN (526)

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): July 14, 15, 16, 17, and 18, 2014

This inspection was conducted simultaneously with inspection H-0000092-14 (CIS 2951-000004-14).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and the Pharmacist.

During the course of the inspection, the inspector(s) reviewed resident health records, reviewed policy and procedures, and observed staff interactions with residents

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee did not ensure that written policies and protocols were developed to ensure the accurate dispensing, receipt, and administration of all drugs in the home.

The home's Medication Policy 06.01.04 for Medication Orders last reviewed on April

19, 2010 directed the nursing staff who transcribed the order to "2. Ensure the medication name and directions are legible"; "5. Flag the chart to signal that another Registered Staff is to recheck orders for transcription accuracy."; and "6. Notify POA if the change in medication is of significance or is a new order and sign appropriate box on order sheet. The nurse receiving the new medication was directed to "12. Check all medication labels against Drug Record Book and Physician's Orders noting the drug name, strength and instruction for accuracy".

Upon admission to the home, resident #004 was prescribed two tablets of a medication to be administered at certain times during each day, as per the resident's medication regime prior to admission. Approximately one week later, the resident's physician wrote a medication order with the same dose and asked staff to 'clarify with pt. times meds given at home'. During interview, the Registered Nurse (RN) who transcribed the order stated that the physician's hand writing was difficult to read; the dose appeared to be three tablets, although could have been interpreted to read two tablets. Two registered staff completed the check of the medication order although the order was not legible. The illegibility of the order was confirmed by the RN, the DOC and the pharmacist.

Interview with the pharmacist who read and filled the order indicated that the prescription was electronically transferred to the pharmacy and appeared to indicate three tablets of medication; the pharmacist stated that they did not question this change from the previous dose of two tabs. In addition, the times of administration needed to be clarified. The pharmacist stated that they contacted the home to clarify the times of administration but did not confirm the proper dose. On the day of the interview, the transcribing RN stated that they could not fully recall what the pharmacist who contacted the home confirmed and what their response was. The staff could not recall if the physician was called to verify the order. Documentation regarding these interactions was absent from the progress notes. The Director of Care (DOC) stated that the RN was called by pharmacy and confirmed that the dosage was three tablets. The prescription was dispensed by the pharmacist so that the resident would receive three tablets and the medication was dispensed to the home. Interview with registered staff indicated that staff would normally confirm the new medication against the physician's order as per policy. There was no documentation to confirm that correct processing of the new prescription was completed after it arrived in the home on the same day the order was written. In addition, there were no signatures to indicate that the Power of Attorney (POA) was notified of a change in dosage of the medication.

According to progress notes from one week after the dosage increased for two to three tablets, resident #004's POA "was concerned that resident was receiving too much [medication]. The dose in the MAR was increased from 2 tabs [medication] to 3 tabs [medication] on [date]. [POA] states resident has increased confusion and has "dulled down". Doctor faxed". On the day the progress note was written, the physician was consulted and indicated to staff that the dose was not meant to be changed, but that the administration times were to be clarified. The physician asked staff to contact the poison control service who directed staff to have resident assessed in hospital. On that same day, the resident was sent to hospital via ambulance at 1800 hours and returned to the home at 2345 hours. The pharmacy was notified of the error and the correct dose was dispensed to the home.

Staff interviewed stated that the physician's hand writing was regularly unclear and that the home had communicated this to the physician on previous occasions. Staff stated they would contact the ordering physician if orders were completely illegible; however staff would attempt to read an order even though it was illegible.

Registered staff who were involved in the management of the medication error confirmed that the physician's hand writing was difficult to read. They also confirmed that the resident appeared to have adverse effects from the increase in the resident's medication. The pharmacist confirmed that the resident received additional tablets for seven days than was intended. The DOC confirmed that the policy required modification to ensure the accurate dispensing, receipt and administration of drugs administered in the home. [s. 114. (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 written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee did not ensure that a written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Progress notes indicated that on a day in 2013 at approximately 2200 hours resident #005 was observed demonstrating a sexual behaviour toward another resident. The following day at 1140 hours, the DOC informed the Director of this critical incident using the Critical Incident System.

The home's Nursing Guidelines Policy 1.1.13 for Resident Abuse last reviewed on November 17, 2011 indicated that "1. Section 24(1) of the LTCHA requires certain persons, including the Home and certain staff members, to make immediate reports to the Director where there is a reasonable suspicion that certain incidents occurred or may occur." Critical incidents that required immediate reporting were outlined in Appendix C and included "2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident".

Two registered staff were interviewed regarding their role in immediately reporting critical incidents to the Director. Both registered staff verified that they were not aware of a requirement for them to immediately notify the Director of a critical incident or that using an after hours telephone line was an option. The Director of Care (DOC) confirmed that the incident occurred. They outlined the home's reporting practice and stated that they would read progress notes each morning for the day before and then would proceed to submit a critical incident notification as necessary. They stated that if critical incidents occurred after hours staff would not directly and immediately report critical incidents to the Director.

The Director of Care (DOC) confirmed that the home's written policy to promote zero tolerance of abuse and neglect of residents had not been complied with in that the critical incident had not been immediately reported to the Director. [s. 20. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee did not ensure that when a resident had fallen, that the resident was assessed and, if required, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #001 sustained a fall on a day in 2014. On that same day, the resident was complaining of left hip pain and was sent to hospital, assessed and subsequently returned to the home. The resident was diagnosed with a fracture that was not treatable. The resident's condition deteriorated and the resident died fifteen days later.

The home's Nursing Policy and Procedure for Falls 03.10.02 "Resident found on the floor" last reviewed on June 23, 2011 indicated that staff were to "Update the Resident's Fall Risk Assessment" for a resident who had fallen. Registered staff interviewed stated that after a resident had fallen the resident was to be assessed using the home's falls assessment instrument. Progress notes indicated that the resident had not been assessed using the home's Falls Risk Assessment after the fall that occurred on that particular day in 2014. Progress notes also indicated that resident #001 had sustained a fall approximately two and one half months earlier and that the resident was not assessed with the home's clinically appropriate assessment instrument. The Director of Care (DOC) confirmed that the assessments for these two falls had not been completed. [s. 49. (2)]

Issued on this 15th day of August, 2014

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