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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 15, 28, 2018	2018_606563_0009	009356-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Women's Christian Association of London
2022 Kains Road LONDON ON N6A 0A8

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

McCormick Home
2022 Kains Road LONDON ON N6K 0A8

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

MELANIE NORTHEY (563), CASSANDRA TAYLOR (725), GLORIA KOVACH (697), INA REYNOLDS (524), JULIE LAMPMAN (522)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 28, 29, 30, 31 and June 1, 4, 5, 6, 7, 8, 2018

The following intakes were completed within the Resident Quality Inspection (RQI):
029073-17 / 2965-000014-17 - Critical Incident related to a fall
001875-18 / 2965-000003-18 - Critical Incident related to resident to resident suspected abuse
005437-18 / IL-56071-LO - Complaint related to bed refusal for Long Term Care admission
029229-17 / 2965-000015-17 - Onsite Inquiry related to suspected staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care, the Assistant Director of Care, the Resident Assessment Instrument Coordinator, the Environmental Service Manager, Housekeeping Aides, the Registered Dietitian, Dietary Aides, Registered Nurses, Registered Practical Nurses, and Personal Support Workers, Resident Council President, Family Council Representative, residents, and family members.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The inspector also made observations of residents and care provided. Relevant policies and procedures, as well as, clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

The current care plan in Point Click Care (PCC) stated a resident required a device for positioning and safety. This intervention was put in place at the time of admission. On multiple occasions the resident device was observed in use. On June 4, 2018, the Personal Support Worker (PSW) stated the resident used a device.

An assessment in PCC stated the resident did not express a desire to have the device engaged for his or her own personal safety and or comfort. The assessment also documented that there were no resident recommendations for the use of the device and the resident's plan of care for the device was documented that it was the resident's choice to not have the device engaged.

The Director of Resident Care (DRC) was asked to review the assessment in PCC and

verified that this was completed during a different stay in the home and verified the assessment documented that there was no device in use by resident choice and that there was no other assessment completed on admission for full stay. The DRC acknowledged that an assessment for the use of the device should have been completed on full stay admission and the care plan updated accordingly. The DRC also reviewed the current care plan and verified that the resident was documented as using the device for positioning and safety. The DRC acknowledged that the plan of care was not based on an assessment of the resident and the resident's needs and preferences related to the use of the safety device.

The licensee failed to ensure that the safety device plan of care was based on an assessment of the resident and the resident's needs and preferences as documented in the assessment in Point Click Care. [s. 6. (2)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Minimum Data Set (MDS) Assessment and Resident Assessment Protocol (RAP) summary indicated the resident had a fall. The RAP note stated that the resident had a specific transfer status and risk assessment score. Review of the Post Falls Assessments documented that the resident had multiple similar incidents.

The current plan of care for the resident under the transfer focus documented that the resident required specific physical assistance with the use of a device. In addition, the plan of care directed staff to implement specific interventions to prevent further incidents. These interventions were also a part of the PCC kardex for the resident.

The inspector observed a Personal Support Worker (PSW) student enter the resident’s room to provide care to the resident that did not match what was documented as part of the resident’s plan of care in PCC. The specific interventions in place to prevent further incidents were noted to be absent.

The Continuing Care Reporting System "(CCRS) MDS Kardex Report for McCormick Home” care card posted on the wall near the resident's room door documented that the resident required specific physical assistance with the use of a device.
During an interview with the PSW student and another PSW, they said that the safety interventions were not in place and the resident did not receive the specific physical assistance with the use of a device as stated in the plan of care.

The Director of Resident Care (DRC) verified that the resident required specific physical assistance with the use of a device and that the PSW student did not follow the plan of care. The DRC verified the use of specific safety interventions for the resident and said that it was the home's expectation that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

A review of the resident's clinical record documented that the Point of Care (POC) task list for the resident directed staff to complete and document identified care tasks for the resident.

Review of the POC intervention/task documentation for the resident for a specific look back period indicated that there were instances where no documentation occurred for the safety interventions on multiple days for multiple shifts. There were also options available to indicate if the resident was not available or refused.

The Director of Resident Care (DRC) acknowledged that the documentation was missing in Point of Care (POC) and that it was the home's expectation that staff sign POC after completion of their tasks.

The licensee has failed to ensure that the provision of care set out in the plan of care was documented. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

The resident was observed with a safety device in place.

Review of the resident's most recent plan of care and kardex on Point Click Care (PCC) noted the absence of documentation related to the use of the device.

The Personal Support Worker (PSW) verified that the resident's device would be applied by staff. When asked how they would know, the PSW indicated it would be noted on Point of Care (POC); however, after review of the POC with the inspector, they were

unable to locate this intervention in the kardex in POC.

The Assistant Director of Care (ADOC) acknowledged that staff would need to apply the device for the resident and stated the care plan should be updated to include the device.

The Director of Resident Care (DRC) verified that the resident had a device that had been in use and acknowledged that the use of the device should be documented in the plan of care and it was not. [s. 6. (10) (b)]

5. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective.

The current care plan in Point Click Care (PCC) stated a resident was at risk for a specific incident characterized by a multiple risk factors. Multiple interventions were in place as part of the resident's plan of care.

The most recently completed specific assessment in PCC indicated the resident overestimated their abilities, forgot limitations and exhibited mood indicators daily.

The resident's room was observed to have a specific identifier on the Continuing Care Reporting System (CCRS) Minimum Data Set (MDS) Kardex Report, on the resident's name plate outside the room, and on the resident's spine of their hard paper chart that indicated a safety risk.

The Personal Support Worker (PSW) shared that the identifier on the CCRS Kardex Report meant that the resident was at a safety risk for a specific incident. The PSW stated the specific incidents were usually at night. The Director of Resident Care (DRC) stated staff were encouraged to look at the transfer status as part of the plan of care and the identifiers related to resident safety risk.

The Quarterly MDS Assessment Resident Assessment Protocols (RAPs) stated the resident required specific physical assistance with the use of a device. The resident also required specific interventions from staff and family. The resident was involved in multiple incidents after bedtime.

The Director of Resident Care (DRC) and the inspector reviewed the multiple incidents where the resident was involved in a particular incident after bedtime. The DRC verified

that there was no documentation that the use of other interventions that could have been used to prevent further incidents were resolved or cancelled as part of the care plan in PCC for this resident. The DRC also acknowledged that there was no referral to Physiotherapy (PT) or PT documentation that the resident was assessed when the current plan of care to prevent incidents was ineffective.

The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective. Intervention strategies including a specific device or a PT referral and assessment of the resident was not considered when the current care plan interventions were ineffective. [s. 6. (10) (c)]

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 the plan of care is based on an assessment of the resident and the resident's needs and preferences, the care set out in the plan of care is provided to the resident as specified in the plan, that the provision of care set out in the plan of care is documented, the resident's plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs changed, and the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan had not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee failed to take into account the assessments and information under subsection 43 (6), and approve an applicant's admission to the home unless: a) the home lacked the physical facilities necessary to meet the applicant's care requirements and b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements.

A complaint was logged with the Ministry of Health and Long Term Care related to the long term stay admission refusal of an applicant. The complainant reported that McCormick Home told them that the applicant required three staff members at all times for care, and that the home only has four staff available on the floor. The complainant also reported that the assessment the Local Health Integration Network (LHIN) sent to McCormick Home may have had some discrepancies and asked the LHIN placement coordinator to reassess the applicant and send the home a second assessment. Both Long Term Care and respite admission was denied. The complainant reported that the local LHIN was encouraging the complainant to move forward with an appeal for the bed refusal.

The three written notices were provided to the inspector setting out the grounds on which the licensee was withholding approval from admission which included the applicant's responsive behaviours, multiple staff assistance at all times to provide care and McCormick lacked the resources to provide this level of care, the applicant's reduction in medication, that the applicant had no physician or clinic visit in over 90 days and that the

applicant was being followed by the Behavioural Response Team (BRT).

The Director of Resident Care (DRC) stated the Administrator, Social Worker or the DRC reviewed the LHIN assessments and information and approved the applicant's admission to the home, but that primarily it was the DRC. The DRC stated that the applicant had a recent respite stay and the resident presented multiple days of unpredictable responsive behaviours at that time. The applicant was resistive to care and required at least two persons, most times three persons with all activities of daily living (ADLs). The DRC stated that training was provided that included techniques and approaches related to responsive behaviours. The training was provided annually and upon hire and then if the resident required extra interventions, the Behavioural Support Ontario (BSO) Registered Practical Nurse (RPN) lead would provide an assessment and specific care plan interventions to help reduce resident responsive behaviours. The DRC stated that the direct care staff have the training and expertise in dealing with responsive behaviours, including aggressive behaviours. All three Charge Nurses had PIECES and Gentle Persuasive Approach (GPA) training.

The PIECES model was designed to provide a practical framework for assessment and supportive care strategies using a comprehensive person-directed which looked at the multiple underlying causes of behavioural expression and associated risks, recognizing areas of need, building on the person's remaining strengths, and considering the person's Physical, Intellectual, and Emotional health, supportive strategies to maximize Capabilities, the individual's social and physical Environment, and his/her Social self. Gentle Persuasive Approach (GPA) training was an evidence based training program that helped care providers deliver person-centred, compassionate care to individuals with dementia. The home had a dementia care unit "Memory Lane" home care area that was a secured unit for those resident's with dementia.

The Director of Resident Care (DRC) also stated that all direct care staff including Personal Support Workers (PSWs) and registered staff received training that included techniques and approaches related to responsive behaviours and aggression. The DRC acknowledged that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours were developed to meet the needs of residents with responsive behaviours. As well, the DRC stated written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours, as well as resident monitoring and internal reporting protocols were developed to meet the needs of residents with responsive behaviours. The DRC stated the home had protocols for the

referral of residents to specialized resources to meet the needs of residents with responsive behaviours. The DRC stated the BSO team in place worked very carefully to provide a communication and approach care plan to address concerns with aggression, agitation and unpredictable responsive behaviours especially around the areas of toileting bathing and dressing, and other care tasks exhibited by the applicant. The BSO lead with their expertise with the BSO and BRT provided assistance to deescalate behaviours and provided the staff with examples to address certain situations common with the applicant.

The McCormick Home Follow Up Question Report in Point Click Care (PCC) for the applicant documented entries related to aggressive behaviours where 17.5 per cent of the entries documented an aggressive behaviour on three of seven days during that time period.

The McCormick Home Follow Up Question Report in Point Click Care (PCC) for the applicant documented entries related to mood indicators where 20 per cent of the entries documented a mood indicator on two of seven days during that time period.

The Medication Administration Record in PCC documented that all medications were administered without refusal by the applicant.

The licensee failed to approve the applicant's admission to the home. The home did not demonstrate grounds for the refusal based on the lack of physical facilities necessary to meet the applicant's care requirements and the DRC stated the staff did have the nursing expertise necessary to meet the applicant's care requirements related to responsive behaviours and medication administration and monitoring of antipsychotic medications. The DRC acknowledged the refusal to admit applicant #011, however was not able to validate the legislative rationale for the refusal as to how the physical facility and staff expertise were unable to meet the needs of the applicant. [s. 44 (7)]

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 take into account the assessments and information under subsection 43 (6), and approve an applicant's admission to the home unless: a) the home lacked the physical facilities necessary to meet the applicant's care requirements and b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that the home had a dining and snack service that included, at a minimum, monitoring of all residents during meals.

An inspector observed that three residents remained in the dining room with food and drink in front of them and no staff were present. A Personal Support Worker (PSW) acknowledged that it was not normal to leave residents sitting in the dining room with food and drink in front of them with no staff present.

An inspector observed a resident sitting at a table in the dining room with food and fluid in front of them approximately two hours after the lunch meal. There were no staff present in the dining room. A PSW stated that the reason that the resident was sitting

alone in the dining room with food in front of them was that it took the resident a long time to eat. The resident was again observed to be alone in the dining room with food and juice in front of them.

The licensee has failed to ensure that three residents were monitored during meals while they were in the dining room with food and drink in front of them. [s. 73. (1) 4.]

2. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

An inspector observed two residents to be sitting at a table in the dining room with their main course meals and fluids in front of them. The two residents had not eaten and there was no staff present at the table to assist them. Both residents required a specific level of physical assistance for eating as part of their current care plan.

On a different day, a resident was observed to have food and fluids in front of them and they were not eating. There was no staff present to assist them. The resident required a specific level of physical assistance for eating as part of their current care plan.

A PSW stated that there were multiple residents who required to be feed on this floor and that unfortunately it was normal to serve residents food and leave it in front of them until someone was available to feed them.

An inspector observed other residents during another meal service where food and fluids were placed in front of the residents and no staff prompting or feeding was provided. Resident care plans identified that the residents required a specific level of physical assistance for eating.

The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the residents.[s. 73. (2) (b)]

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 the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals and to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On the Maple Grove unit, two locked controlled substance storage areas in the medication cart were observed. The locked area on the right side of the cart was observed to contain a manila envelope that registered staff stated contained bus tickets for a resident and a fabric case that contained bus tickets and money for another resident. When asked why these items were in the locked controlled substance area,

Registered Practical Nurses (RPNs) stated that they do not usually keep items in the locked box however these were for residents with difficult issues and they thought arrangements had been made to ensure these items were kept there.

The Director of Resident Care (DRC) stated that the locked boxes for controlled substances should only contain narcotics as per the Silver Fox Pharmacy manual and that sometimes large sums of money or a ring may be locked up in that area for a short period of time until it can be brought to reception. The items that were found in the narcotics locked box on Maple Grove unit could have been kept in the locked medication room.

The Silver Fox Pharmacy "Drug Storage Policy 7" last revised October 2017 did not state that only drugs and drug-related supplies should be stored in the locked box on the medication cart.

The McCormick Home Medications Policy NPC-1300-17 last revised June 2018 did not document that only drugs and drug-related supplies should be stored in the locked box on the medication cart.

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies. r.129(1)(a)(i) [s. 129. (1) (a)]

2. The licensee failed to ensure controlled substances were stored in a separate, double-locked stationary cupboard in a locked area.

On Maple Grove unit, controlled drugs were observed stored in a black locked box in a locked fridge in the locked medication room. The black locked box was removable and not stationary in the refrigerator.

A temporary license RPN verified that the black box containing narcotics was removable from the refrigerator.

On Evergreen Walk unit, the inspector observed a controlled substance in a locked fridge in the locked medication room. The controlled substance was removable, not stationary and not double locked in the refrigerator.

The DRC stated that the controlled drugs in the refrigerator on Maple Grove unit were

triple locked and acknowledged that the locked box inside the refrigerator was removable. The DRC stated that they were advised by Silver Fox Pharmacy that the refrigerated controlled drug storage on Maple Grove unit was compliant.

The Silver Fox Pharmacy "Drug Storage Policy 7" last revised October 2017 did state that controlled substances must be stored separately in a double-locked area, but did not indicate a stationary cupboard in a locked area.

The McCormick Home Medications Policy NPC-1300-17 last revised June 2018 stated the medication room must be locked at all times, and intramuscular (IM) injectable Ativan in the emergency box needs to be kept in the medication fridge on Maple Grove. It further documented that the narcotic cupboard was to be under double lock at all times.

The licensee failed to ensure controlled substances were stored in a separate, double-locked stationary cupboard in a locked area. [s. 129. (1) (b)]

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 stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies and to ensure controlled substances are stored in a separate, double-locked stationary cupboard in a locked area, to be implemented voluntarily.

WN #5: 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).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A) A resident was identified to have a specific medication order. A medication incident documented that a RPN discovered the wrong medication administered in error. The DRC confirmed that the resident received a medication that was not ordered by the physician.

B) A medication incident documented that a resident was given medications that were not ordered for the resident and that belonged to a different resident. The Professional Advisory Committee (PAC) meeting documented that the wrong medication was administered to the wrong resident. The Registered Nurse (RN) stated that they had given the resident the wrong medication by accident.

The licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident. [s. 131. (1)] (725)

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The electronic Medication Administration Record for a resident identified medications scheduled for 0800 hours. A medication incident identified the medications were still in the packaging and had not been administered to the resident as prescribed. The Director of Resident care (DRC) verified that the resident did not receive the medication as prescribed.

The licensee has failed to ensure that drugs were administered to the resident 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 no drug is used by or administered to a resident in the home unless the drug had been prescribed for the resident and to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: 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. (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 a written record was kept of a quarterly review 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 and any changes and improvements identified in the review were implemented.

A) On review of the last full quarter of medication incidents there was no documentation to support that a quarterly review had been undertaken to identify factors to reduce and prevent medication incidents and adverse drug reactions, as well as no documentation to indicate that changes and improvements have been identified in the review and implemented. The DRC stated that the medication incidents were discussed during the

last quarterly Professional Advisory Committee (PAC) meeting but there was no written documentation to support that a review was completed to reduce and prevent medication incidents and adverse drug reactions, and any changes and improvements identified in the review were implemented.

B) The Home's Performance Improvement Team (PIT) quarterly meeting minutes documented a summary of the medication errors for a three month period, however there was no documentation on review of how to reduce or prevent medication incidents or adverse drug reactions. The minutes did not identify any changes or improvements.

The home's PAC minutes documented a medication incident summary, but here was no documentation of how to reduce or prevent medication incidents or adverse drug reactions. The minutes did not identify any changes or improvements.

The home's medication incident summary for the quarter documented the medication incidents during that quarter. There was no documentation of how to reduce or prevent medication incidents or adverse drug reactions. The minutes did not identify any changes or improvements.

The Assistant Director of Care (ADOC) stated that all investigation notes for medication incidents were documented on the medication incident report. The Director of Resident Care (DRC) stated that the process to identify ways to reduce and prevent medication incidents and preventative measures to be implemented were done quarterly at the home 's PAC meeting however it was not written in the PAC minutes and that the home did not document it.

The licensee has failed to ensure that a written record was kept of a quarterly review 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 and any changes and improvements identified in the review were implemented. [s. 135. (3)]

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 a written record is kept of a quarterly review 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 and any changes and improvements identified in the review are implemented, to be implemented voluntarily.

Issued on this 28th day of June, 2018

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

Original report signed by the inspector.