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

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 4, 2016	2015_303563_0053	026344-15	Complaint

Licensee/Titulaire de permis

SHARON FARMS & ENTERPRISES LIMITED
1340 HURON STREET LONDON ON N5V 3R3

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

Earls Court Village
1390 Highbury Avenue North LONDON ON 000 000

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

MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 7, 8 and 9, 2015

This complaint inspection was related to air temperatures, availability of nutritional interventions, snack service and the safe administration of medications.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Acting Director of Care, the Maintenance Manager, Director of Dietary Services, the Geriatric Clinical Nurse Specialist, two Registered Practical Nurses, two Dietary Aides, one Personal Support Worker and one Resident.

The inspector(s) also 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. The home's internal investigation records were also reviewed. Inspector(s) observed meal service, one medication storage area and dietary storage areas.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Dining Observation
Medication
Personal Support Services

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	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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for all medication incidents and adverse drug reactions, corrective action was taken as necessary.

Record review of the Critical Incident (CI) Report # 3047-000013-15 revealed resident # 005 was administered resident # 006's medications during the 0800 hour medication administration on this date. The "Analysis and Follow-Up" section in the CI Report stated, "spoke to pharmacy and we are getting name alert stickers, and behind the scenes the names have asterisks beside them to make staff aware of the name alert."

Record review of a progress note revealed resident # 005 reported to a Registered Practical Nurse that the wrong pills may have been administered.

Record review of the "MD Progress Note" revealed a medication error occurred.

Staff interview with the Administrator confirmed that for resident # 005 or resident # 006 there were no asterisks beside either name in PointClickCare (PCC) or on the electronic Medication Administration Record (eMAR) and could not confirm if alert stickers were ordered or if the resident's individual medication bins have been asterisked.

Observation of the medication cart revealed there were no name alert stickers for either resident # 005 or resident # 006 on their individual strip packs in the medication cart.

Observation of the eMAR with the Registered Practical Nurse (RPN) in attendance revealed there were no asterisks for either resident on their individual bins in the medication cart and no asterisks on either residents' PCC profile or in the eMAR.

Staff interview with the RPN confirmed that there were no name alert stickers on the medication strip packs for resident # 005 or resident # 006. The RPN also confirmed that there were no asterisks beside resident # 005 or # 006's name either in PCC eMAR or on the residents' individual medication bins. The RPN shared that there has never been any name alert stickers used or asterisks to identify the name alert as far as she knows, confirming corrective action was not taken as necessary to help minimize reoccurrence. [s. 135. (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 for all medication incidents and adverse drug reactions, corrective action is taken as necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, a medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

Record review of the Critical Incident (CI) Report # 3047-000013-15 revealed the CI was first submitted to the Ministry of Health and Long Term Care (MOHLTC) seven days after the incident occurred.

Record review of a progress note revealed an error was made where by resident # 005 was administered another resident's medications and was transferred to hospital.

Staff interview with the Administrator confirmed the CI was submitted to the MOHLTC seven days after the incident took place. The Administrator also confirmed that an after-hours call was not made to the MOHLTC no later than one business day after the incident. [s. 107. (3) 5.]

Issued on this 12th day of January, 2016

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

Original report signed by the inspector.