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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 23, 2016	2016_303563_0018	014119-16	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): June 13 - 17 and 21, 2016

This inspection was related to a complaint regarding medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Registered Practical Nurses, the Pharmacist and one resident.

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

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	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. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policies and protocols related to safe medication management were developed, implemented, evaluated and updated in accordance with evidence-based practices.

Record review of the "Administration of Medications" Policy # NAM-G-05 last revised February 2016 stated, "Remain with each Resident until the medication has been swallowed; otherwise, it cannot be considered administered (if applicable)."

Record review of the "Medication / Treatment Standards: Medication Incidents" policy # NAM-G-100 with an effective date January 2014 stated, "All medication incidents will be reported and documented to ensure ongoing trending and analysis and that future risk is mitigated." The policy stated, "when a medication incident is discovered, it must be reported immediately to the Director of Care (DOC) / designate, the physician, the pharmacist and the Substitute Decision Maker" and "when a medication incident occurs, a Medication Incident Report (hard copy) [provided by pharmacy provider] must be completed by the person finding the incident and submitted to the Administrator or DOC / designate." "The completed Medication Incident Report (hard copy) will be kept by the DOC / designate in a separate binder, as per the home/residents policy for analysis and trending."

Record review of the progress notes for this resident identified that the resident was given wrong medication in the morning. The resident recognized that the wrong pills were received.

A resident stated in an interview that the pills were placed on a table in a common area and the medication cup was half full and the resident said that they take less pills than that in the morning.

The RPN # 129 explained during an interview that she placed the medications in an area also accessible to other residents. The resident reached for the cup of medications and realized they were not meant for her.

The Director of Care #102 stated in an interview that there was no medication incident report completed in the Medication Error binder in her office and said the medication error was not in the complaint binder. The DOC stated that a medication error report should have been completed.

The Administrator said during an interview that the RPN did not follow the home's policy related to medication errors and did not stay with the resident during the administration of medications to ensure the medications were taken. [s. 114. (3) (a)]

Issued on this 23rd day of June, 2016

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

Original report signed by the inspector.