Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: August 18, 2023	
Original Report Issue Date: August 14, 2023	
Inspection Number: 2023-1475-0005 (A1)	
Inspection Type: Complaint Critical Incident System	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Earls Court Village,London	
Amended By Brandy MacEachern (000752)	**Inspector who Amended Digital Signature** Brandy MacEachern (000752)

AMENDED INSPECTION SUMMARY

This report has been amended to:
This report has been updated to correct the Licensee report issue date, there has been no changes to any other aspect of this report.

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Long Term Care Home and City: Earls Court Village, London	
Lead Inspector Brandy MacEachern (000752)	**Additional Inspector(s)** Debbie Warpula (577)
Amended By Brandy MacEachern (000752)	**Inspector who Amended Digital Signature** Brandy MacEachern Digitally signed by Brandy MacEachern Date: 2023.08.18 18:29:48 -04'00'

AMENDED INSPECTION SUMMARY

This report has been amended to:
This report has been updated to correct the Licensee report issue date, there has been no changes to any other aspect of this report.

INSPECTION SUMMARY

August 8-11, 2023, with August 8-10, 2023 conducted on-site and August 11, 2023 conducted off-site.

The following critical incident (CI) intake(s) were inspected:

- Intake: #00091415 / CI# 3047-000017-23 related to a medication incident.

The following complaint intake(s) were inspected:

- Intake: #00093616 related to air conditioning.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Safe and Secure Home
Infection Prevention and Control

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Resident Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 19. ii.

Non-compliance with: FLTCA, 2021 s. 3 (1) 19. ii
The licensee has failed to ensure that a resident was given the right to refuse consent of the administration of unprescribed medications.

Rationale and Summary
During an interview with a registered nursing staff member, they advised that they administered a medication to a resident without their consent.

In an interview with the Director of Care (DOC) they confirmed the staff had not allowed the resident the right to refuse when they administered medication, resulting in medication errors.

The resident was at risk when their right to refuse was not acknowledged.

Sources: Critical Incident (CIS) System Report, two medication incident reports, CareRX policy "Medication Administration" revised August 2021, health records for residents, and interviews with staff members. [577]

WRITTEN NOTIFICATION: Medication Management

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
The licensee has failed to comply with CareRX medication policies related to medication administration

and medication incidents included in the required Medication Management Program.

In accordance with O. Reg. 246/22, s. 11 (1) (b) the licensee is required to ensure that written policies and protocols were developed for the medication management system and ensure they were complied with.

Specifically, a registered nursing staff did not comply with CareRX policies “Administration of Medications” and “Medication Administration” and a different registered nursing staff did not comply with CareRX policy "Medication Incident Report".

Rationale and Summary
A review of CareRX policies “Administration of Medications” and “Medication Administration” indicated that medications were administered only after the ten rights had been checked by the registered staff; staff were to have provided appropriate documentation and identified the resident by using the Medication Administration Record (MAR) picture before giving the medication. Additionally, all medication incidents were to be responded to, documented and reported to the DOC/designate immediately.

A review of CareRX policy "Medication Incident Report" indicated that the nurse initiating the incident report must document the medication involved and indicate whether it was high alert (yes/no).

A review of the home’s investigation notes indicated that a staff member had administered several medications to the incorrect resident.

A review of the medication incident report that involved the administration of a medication, had not included the name of the medication or indication whether it was high alert.

During an interview with a registered nursing staff, they advised that they administered the incorrect resident's medications. they addressed the resident by another resident's name; and the resident refused the medication. They stated that they had not checked the resident picture on the eMAR and had not brought the medication cart into the resident’s room. They said that they had not immediately reported the medication error and reported it after they took their break. The registered nursing staff member also said they had not reported the medication error involving the administration of the six other medications administered until six days later and falsely documented in the resident’s progress notes that they had not administered medication. They confirmed that they had not followed the home’s medication policies by not following the medication rights, not immediately reporting the medication error and falsely documenting in the resident's progress notes that medication wasn’t administered.

In an interview with the DOC they advised that the staff member failed to follow CareRX medication policies by not properly identifying the resident, which resulted in medications given in error, they had not followed the medication rights, specifically the right person, the right medication and the right to refuse. The registered nursing staff member had not immediately reported the medication errors as they had waited 20 minutes after administering the medication, before reporting. They said that the registered nursing staff member had not reported the administration of the wrong resident's medications, until six days after the medication administration. In addition, the staff member had falsely documented in the resident's progress notes that they had not administered medication. The DOC acknowledged that the staff member had not included the name of the medication and whether the medication was of high alert on the medication incident report.

The resident was at risk when they were administered the medication and at risk when the home was not aware of the six additional medications that were administered, until six days later.

Sources: Critical Incident (CIS) System Report, two medication incident reports, CareRX policy "Administration of Medications" revised November 3, 2022, "Medication Administration" revised August 2021, "Medication Incident Report" revised May 2022, health records for residents, and interviews with staff members. [577]

WRITTEN NOTIFICATION: Medication Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

Non-compliance with: O. Reg. 246/22, s. 140 (2)
The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A review of the home's investigation notes indicated that a registered nursing staff member had administered several medications to the incorrect resident.

During an interview with the staff member, they advised that they administered the incorrect resident's medications. They stated that they had not checked the resident picture on the eMAR and they addressed the resident by the incorrect name. They confirmed that they had falsely documented in the resident's progress notes that the medication was not administered. They acknowledged that they had

not followed the medication rights during medication administration.

In an interview with the Director of Care (DOC) they confirmed that the staff member had not followed the medication rights, specifically the right resident, right medication, and the right to refuse when they administered the medication, resulting in medication errors.

The resident was at risk when they were administered medications which were not prescribed to them.

Sources: Critical Incident (CIS) System Report, two medication incident reports, health records for residents, and interviews with staff members. [577]