Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2020	2020_755728_0002	020027-19, 021073-19, 024227-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

MARIA MCGILL (728)

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): January 13 - January 16, 2020.

The following intakes were completed in this Critical Incident System Inspection:

Log #024227-19 and Log #021073-19, related to responsive behaviours; and, Log #020027-19, related to missing controlled substances.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Clinical Nursing Consultant (PrimaCare), Registered Nurses (RN), Behavioural Support Ontario Registered Practical Nurse (BSO RPN), and Personal Support Workers (PSW).

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, medication count documentation, and relevant home documentation.

Observations were made of residents, staff to resident interaction, resident care provision, medication administration, and narcotic count.

The following Inspection Protocols were used during this inspection:
Medication
Responsive Behaviours

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	Légende 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee failed to ensure that every mediation incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A Critical Incident (CI) was submitted to the Ministry of Long-term Care (MLTC) related to an incident where staff reported a missing controlled substance for #005, #006, and #007, that was identified during a between shift count.

Resident #005, #006, and #007 had been prescribed specified medications.

Specified registered staff completed a count of identified medications and noted a discrepancy. The registered staff were unsure how the incident occurred. The previous DOC #110 was notified immediately.

There was no documentation in resident #005, #006, and #007's clinical records to support that they were monitored after the home became aware of the potential risk. The CI documented that the home's physician was notified and that they suggested continued monitoring.

DOC #100 said that a medication incident report was not completed related to the incidents. They said a medication incident report should have been completed and that residents should be monitored following a medication incident.

The licensee failed to ensure that when a medication incident occurred with a high risk medication for residents #005, #006, and #007, that it was documented, a medication incident report was completed, and that immediate actions to maintain and assess the residents health were taken. [s. 135. (1)]

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 every mediation incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, 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):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has 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 an incident in which there was a missing or unaccounted for controlled substance.

A CI was submitted on an identified date which documented that three residents were missing identified medications two business days prior.

RN #108 said the DOC at the time of the incident #110 was aware of the incident the day that it occurred.

The licensee failed to report missing uncontrolled narcotics for resident #005, #006, and #007 within one business day of the incident occurring. [s. 107. (3) 3.]

Issued on this 23rd day of January, 2020

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

Original report signed by the inspector.