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

North District
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Original Public Report

Report Issue Date: March 9, 2023	
Inspection Number: 2023-1206-0004	
Inspection Type: Complaint	
Licensee: The District of the Municipality of Muskoka	
Long Term Care Home and City: Fairvern, Huntsville	
Lead Inspector Tracy Muchmaker (690)	**Inspector Digital Signature** Tracy L Muchmaker Digitally signed by Tracy L Muchmaker Date: 2023.03.14 13:33:55 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 13-16, 2023
The following intake(s) were inspected:

- One intake, which was a complaint related to a resident's medication management.

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

Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Integration of assessments, care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee has failed to ensure that staff and others involved in the different aspects of care of a resident collaborated with each other in the assessment, development, and implementation of the plan of care.

Rationale and Summary

A resident's consulting Physician had ordered a specified medication to be given as needed with directions for staff to implement an intervention prior to giving the medication. The specified directions were to be incorporated into the resident's plan of care.

Progress notes documented by the resident's attending Physician indicated that they would re-assess the medications based on whether staff would need to utilize the medication. The resident's electronic medication administration record (eMar) indicated that the resident had received the medication on a number of occasions during a three-month period. There was no documentation to indicate that the Physician had been made aware, and the resident's care plan and eMar did not contain information related to implementing the intervention prior to administering the medication, until concerns were brought forward.

Registered staff and the Director of Care (DOC) agreed that the information related to implementing the identified intervention, should have been added to the care plan on Point Click Care (PCC), or the eMar, so that all staff would be aware. They also agreed that staff should have collaborated with the Physician about the use of the medication at the time it occurred.

Not having the information related to implementing the identified intervention prior to the use of the medication identified on the care plan or eMar, and not collaborating with the resident's Physician related to the use of the medication posed a moderate risk to the resident.

Sources: A resident's eMar records and progress notes; interviews with Registered staff and the DOC. [690]

WRITTEN NOTIFICATION: Involvement of resident, etc.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that a resident's substitute decision maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Rationale and Summary

A resident's consulting Physician had ordered a specified medication to be given as needed with specified directions for staff to follow when administering the medication.

The resident's eMar indicated that the resident was administered the medication on a number of occasions over a three-month period. There was no documentation to indicate that the resident's SDM was notified.

Registered staff and the DOC confirmed that the resident's SDM was not made aware of the administration of the medication, and that there had been specific instructions for staff to notify the SDM if the medication was required.

Not involving the resident's SDM in the implementation of the plan of care posed a moderate risk to the resident.

Sources: A resident's health records; interviews with Registered staff and, the DOC.
[690]

WRITTEN NOTIFICATION: Consent

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 7

The licensee has failed to ensure that no care or services was provided to a resident without consent.

Rationale and Summary

A progress note and other health records identified that a resident had received a specified treatment, despite documentation that indicated that the SDM had refused to give consent.

Registered staff and the DOC verified that the resident received the treatment in error as the SDM had previously refused consent.

Administering the treatment to the resident without consent posed a moderate risk to the resident.

Sources: A resident's progress notes, and other health records; interviews with Registered staff and the DOC.
[690]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 as specified by the prescriber.

Rationale and Summary

1) A resident's consulting Physician had ordered a medication and provided specified directions for use of the medication. Progress notes indicated that the medication was administered on a number of occasions over a three-month period, and there was no evidence to indicate that the specified directions from the Physician were followed.

A Registered Nurse (RN), and the DOC agreed that according to the documentation, the medication was not administered according to the specified directions provided by the Physician.

Not administering the medication to the resident as per the directions of the prescriber, posed a moderate risk to the resident.

Sources: A resident's health records; interviews with an RN, and the DOC.

2) A resident had a medication ordered and there were specific directions for staff to follow when administering the medication. Progress notes indicated that on an identified number of occasions during a one-month period, staff had discovered that the specified directions had not been followed.

An RN and the DOC verified that the medications were not administered according to the directions of the prescriber.

Not administering the medication to the resident as per the directions of the prescriber, posed a moderate risk to the resident.

Sources: A resident's medication orders, and progress notes; Interviews with an RN, and the DOC. [690]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 147 (1)

The licensee has failed to ensure that every medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and was reported to the resident, the resident's substitute decision-maker, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician, and the pharmacy service provider.

Rationale and Summary

A resident had a medication ordered and there were specific directions for staff to follow when administering the medication. Progress notes indicated that on an identified number of occasions during a one-month period, staff had discovered that the specified directions had not been followed.

An RN recalled being made aware of at least one incident and could not recall if they had filled out a medication incident report. The DOC verified that there should have been medication incident reports for the incidents, and that they could not locate a report for any of the three incidents.

Not completing a medication incident report for the medication incidents posed a low risk to the resident.

Sources: A resident's eMar records, and progress notes; Interviews with Registered staff and the DOC. [690]