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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 13, 2017	2017_603194_0020	009086-17	Follow up

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street COBOURG ON K9A 5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET COBOURG ON K9A 5J6

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): July 5, 6 and 7, 2017

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care (ADOC), Registered Nurse (RN) and Registered Practical Nurse (RPN)

The inspector observed the medication carts, Narcotic count and reviewed relevant medication documentation.

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)
1 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. (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 :

1. The licensee has failed to ensure that every medication incident involving a resident is documented and a record of the immediate actions are taken to assess and maintain the resident's health.

A compliance order (CO) was issued the home on April 20, 2017 under report # 2017_603194_0010 related to O.Reg 79/10 s. 135;
the home was to be compliant by June 30, 2017. The CO required the home to;
-Develop and implement an effective formal monitoring process to evaluate medication administration processes to promptly identify and address medication incidents to prevent re-occurrence and avoid adverse medication incidents.
-Implement immediate actions for medication incidents reported, specifically with high risk drugs
-Provide formal education for Registered staff related to identified medication policies
-Analyze the home's medication incident reports monthly to determine corrective action and medication trends for the purpose of reducing medication incidents, until such time a s compliance is achieved.

On July 5, 2017 inspector #194 reviewed information outlining what the home had completed for compliance. ADOC # 2 indicated during an interview with inspector # 194 that the "Medication Incident Summary for 2017 Golden Plough Lodge" was being completed to include all of the medication incidents reported in the home. Inspector #194

was informed that this spreadsheet was updated to ensure up to the moment quick view of all medication incidents, causative factors, Registered staff responsible for the errors, harm to resident, notification of DOC/Pharmacy and counseling/supervision of Registered staff involved.

Review of the Medication Incident Summary form was completed by inspector #194 for the period of April to June 2017. Upon review it was noted that a number of action plans and root cause analysis had not been completed for the identified medication errors. During interview with RPN # 104 inspector #194 was informed that a medication incident report in June had been submitted by RPN#104 involving a narcotics, this medication incident was also missing from the Medication Incident Summary. During interviews with both ADOC #1 and #2 the missing June medication incident was discussed but the medication incident report was never located. ADOC #2 indicated during same interview that the Registered staff had been provided some documentation education in May 2017 which included how to complete the Medication incident report and responsibilities for the RN to complete the mentoring/counseling with staff at the time of the incident.

Inspector #194 was informed by ADOC #1 and #2 during interview that the Medication Incident Summary was to be reviewed and analyzed by DOC at the end of the month. Review of the Medication Incident Summary for the period of April 2017 to June 2017 was completed with no evidence of an analysis having been completed for the period reviewed. During the review of the Medication Incident Summary and Medication Incident report it was noted that a total of 7 medication incidents involving high risk medication had occurred between April and June 2017, with only 5 of the medication incidents having an immediate action initiated.

Review of the Medication Incident Summary completed by inspector #194 also indicated that pharmacy errors were identified between May 4 and June 28, 2017.

During interview with ADOC #2, inspector #194 was informed that the home had provided medication policy packages to all registered staff at the home, with a few packages outstanding (not returned/completed) on July 7, 2017. Inspector #194 was informed by ADOC #2 that formal education was to be provided by the pharmacy provider but could not be completed until July 24 and August 10, 2017(post compliance date).

The Compliance Order under O. Reg 79/10, s. 135 will not be complied during this inspection related to the formal education on medication policies not being provided prior

to the compliance date, no immediate action taken for the reported high risk medications incidents and no monthly analysis of the medication incidents to determine corrective action and medication trends for the purpose of reducing medication incidents. [s. 135. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of October, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194)
Inspection No. / No de l'inspection :	2017_603194_0020
Log No. / No de registre :	009086-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 13, 2017
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND 983 Burnham Street, COBOURG, ON, K9A-5J6
LTC Home / Foyer de SLD :	GOLDEN PLOUGH LODGE 983 BURNHAM STREET, COBOURG, ON, K9A-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Clare Dawson

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2017_603194_0010, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(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).

Order / Ordre :

The licensee shall:

a) Implement immediate actions and analysis for medication incidents reported, specifically with high risk drugs or pharmacy errors.

b) Provide formal education for Registered nursing staff related to Medication policies, as previously ordered, specifically;
-Medication Incidents Policy #4.15
-Documentation of Narcotic and Controlled Medication Policy #4.19
-Medication Administration Pass Policy #4.6
-Medication Administration Documentation Overview Policy #4.1
-Receiving Narcotic and Controlled Medications Policy#6.8

c) Analyze all of the home's medication incident reports at least monthly to determine trends for the purpose of reducing medication incidents.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident is documented and a record of the immediate actions are taken to assess and maintain the resident's health.

A compliance order (CO) was issued the home on April 20, 2017 under report # 2017_603194_0010 related to O.Reg 79/10 s. 135;
the home was to be compliant by June 30, 2017. The CO required the home to;
-Develop and implement an effective formal monitoring process to evaluate medication administration processes to promptly identify and address medication incidents to prevent re-occurrence and avoid adverse medication incidents.
-Implement immediate actions for medication incidents reported, specifically with high risk drugs
-Provide formal education for Registered staff related to identified medication policies
-Analyze the home's medication incident reports monthly to determine corrective action and medication trends for the purpose of reducing medication incidents, until such time a s compliance is achieved.

On July 5, 2017 inspector #194 reviewed information outlining what the home had completed for compliance. ADOC # 2 indicated during an interview with inspector # 194 that the "Medication Incident Summary for 2017 Golden Plough Lodge" was being completed to include all of the medication incidents reported in the home. Inspector #194 was informed that this spreadsheet was updated to ensure up to the moment quick view of all medication incidents, causative factors, Registered staff responsible for the errors, harm to resident, notification of DOC/Pharmacy and counseling/supervision of Registered staff involved.

Review of the Medication Incident Summary form was completed by inspector #194 for the period of April to June 2017. Upon review it was noted that a number of action plans and root cause analysis had not been completed for the identified medication errors. During interview with RPN # 104 inspector #194 was informed that a medication incident report in June had been submitted by RPN#104 involving a narcotics, this medication incident was also missing from the Medication Incident Summary. During interviews with both ADOC #1 and #2 the missing June medication incident was discussed but the medication incident report was never located. ADOC #2 indicated during same interview that the Registered staff had been provided some documentation education in May 2017 which included how to complete the Medication incident report and

responsibilities for the RN to complete the mentoring/counseling with staff at the time of the incident.

Inspector #194 was informed by ADOC #1 and #2 during interview that the Medication Incident Summary was to be reviewed and analyzed by DOC at the end of the month. Review of the Medication Incident Summary for the period of April 2017 to June 2017 was completed with no evidence of an analysis having been completed for the period reviewed. During the review of the Medication Incident Summary and Medication Incident report it was noted that a total of 7 medication incidents involving high risk medication had occurred between April and June 2017, with only 5 of the medication incidents having an immediate action initiated.

Review of the Medication Incident Summary completed by inspector #194 also indicated that pharmacy errors were identified between May 4 and June 28, 2017.

During interview with ADOC #2, inspector #194 was informed that the home had provided medication policy packages to all registered staff at the home, with a few packages outstanding (not returned/completed) on July 7, 2017. Inspector #194 was informed by ADOC #2 that formal education was to be provided by the pharmacy provider but could not be completed until July 24 and August 10, 2017(post compliance date).

The Compliance Order under O. Reg 79/10, s. 135 will not be complied during this inspection related to the formal education on medication policies not being provided prior to the compliance date, no immediate action taken for the reported high risk medications incidents and no monthly analysis of the medication incidents to determine corrective action and medication trends for the purpose of reducing medication incidents. [s. 135. (1)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 13th day of July, 2017

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Chantal Lafreniere

Service Area Office / Bureau régional de services : Ottawa Service Area Office