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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
May 20, 2015	2015_295556_0011	O001554-15, O-001361-14	Complaint

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

ALMONTE COUNTRY HAVEN
333 COUNTRY STREET P.O. BOX 250 ALMONTE ON K0A 1A0

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

WENDY PATTERSON (556)

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): April 13, 14, 16, 17, 2015

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the RAI Coordinator, the Registered Dietitian (RD), and a Resident's Substitute Decision Maker (SDM).

During the inspection the Inspector reviewed resident health care records, several critical incident reports, several policies, internal investigation documentation, the narcotics binder, several medication incident reports, and observed resident lunchtime meal service.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration
Personal Support Services

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Medication Incident Report policy was complied with.

Ontario Regulations 79/10, s. 114 (2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The Director of Care (DOC) stated that the home follows medication policies provided by their pharmacy service provider Medical Pharmacies.

The Medical Pharmacies Pharmacy Policy & Procedure Manual for Long Term Care was reviewed and Section 9 Reporting and Communications, Policy 9-6 entitled Medication Incident Report, Procedure #1 and #4 stated that when a medication incident occurs a medication incident report is to be completed and submitted to the DOC.

The Critical Incident Report submitted by the home to the MOHLTC was reviewed and indicated that on a specific date a transdermal narcotic was administered to Resident #001 and the next day the narcotic patch was missing.

The physician's order stated that Resident #001 was to have one transdermal narcotic patch applied every 3 days.

In an interview the DOC stated that she was made aware of the missing transdermal narcotic three days after the incident had occurred, at which time she reported the incident to the MOHLTC. The DOC further stated that when she investigated the incident she found that the RN on duty at the time of the incident had not completed a medication incident report, nor had she reported the incident to the DOC. The DOC stated that the medication incident report should have been completed at the time of the incident and submitted to the DOC so that she received it the next business day.

Upon further review of an additional 6 Critical Incident Reports submitted by the home to the MOHLTC it was noted that in a specific month four separate incidents of missing transdermal narcotics occurred involving 3 different residents where the registered staff did not complete a medication incident report. [s. 8. (1) (b)]

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Issued on this 20th day of May, 2015

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

Original report signed by the inspector.