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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 2, 2015	2015_291552_0004	O-000904-14	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

MARIA FRANCIS-ALLEN (552)

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): January 8, 9 & 29, 2015

Complaint log # 000904-14

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and family member.
The inspector also reviewed the Medication policies, Plans of Care and other documentation within the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Regarding log # 000904-14 related to Resident # 003

The MOHLTC was advised by the Power Of Attorney (POA) for Resident # 003 that the resident received the wrong medication daily over identified dates.
Review of the incident report completed by the Director of Care indicated that this medication was prescribed for Resident # 004 who had the same first name as Resident # 003 and resided on another unit. During the processing of the order, the Pharmacy staff was unable to read the surname indicated on the physician's order and selected Resident # 003 as he/she was the only resident listed in the home with that particular first name. Resident # 004 is listed under a different name on the pharmacy files.

During an interview with Staff # 101, the staff reported not being aware of the medication incident as Resident # 004 was receiving the medication as ordered by the MD and Resident # 003 resides on a different unit.
Staff # 101 explained that when the physician writes an order for a new medication, the Registered staff would contact the pharmacy (via telephone) and fax the order. The resident and/or family member would be contacted about the new medication.
Once the medication has arrived from the pharmacy, the Registered Staff is responsible for checking the medication against the physician's order to ensure that it is correct. The Registered Staff would also document on the 24 hour report that the new medication has started and the resident is to be monitored for side effects.

During an interview with Staff # 100, the staff explained that when the medication arrives from pharmacy, the home's process is that it is checked by the Registered Staff along with the physician's order.Staff # 100 is knowledgeable of the process outlined in the home's policy of the process once a medication error has been identified.

The Director of Care acknowledged during an interview that an error was made, all the parties involved in the incident had met and processes have been reviewed to prevent this from re-occurring. The resident was assessed and monitored and exhibited no adverse effects.

Resident # 003 was observed during the course of the inspection, but the inspector was unable to interview the resident because of his/her cognitive status.

Review of the clinical health records for Resident # 003 showed that this medication had been administered to resident even though it had not been ordered. [s. 131. (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 by ensuring that upon receipt from the pharmacy, all medication are checked against the physician orders so that no drug is used or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 2nd day of March, 2015

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

Original report signed by the inspector.