Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 30, 2018	2018_589641_0030	017962-18, 019889-18	Complaint

Licensee/Titulaire de permis

Broadview Nursing Centre Limited
210 Brockville Street Smiths Falls ON K7A 3Z4

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

Broadview Nursing Centre
210 Brockville Street Smiths Falls ON K7A 3Z4

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

CATHI KERR (641)

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): October 3, 4 and 5, 2018.

This inspection was conducted following a complaint, Log #019889-18 related to resident care and a critical incident, Log #017962-18, CIS #2684-000006-18 related to a fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses, Registered Practical Nurses and Personal Support Workers.
During the course of the inspection, the Inspector reviewed resident health care records, Critical Incident System reports (CIS) and relevant licensee investigation notes, falls prevention and procedures related to pain management.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain

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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to the resident in accordance with the directions for use specified by the prescriber.

An inspection was conducted in relation to Complaint Log #019889-18, which indicated that resident #001 had not received a specified medication for several days after it had been ordered.

Inspector #641 reviewed resident #001's health care record which included documentation that the resident had returned from the hospital on a specified date, with a prescription for a specified medication. The documentation on the resident's Doctor's order sheet indicated that the prescription received from the hospital had been faxed to the pharmacy the day after returning from the hospital and a second order for the medication was received on that same date. The first dose of the medication that the resident received was three days after the resident had been ordered the medication.

Inspector #641 reviewed resident #001's electoric Medication Administration Record (eMAR) which indicated that after the order for the medication was received on the specified date and when the medication was first given three days later, there were three occasions when the resident complained of pain and was given an alternate medication.

During an interview with Inspector #641 on October 5, 2018 at 1140 hours, the Director of Care (DOC) indicated that the expectation of the home was that if a resident had a new order for a specific medication on the weekends, the registered nursing staff would either borrow that medication from another resident, call the doctor to see if another medication could be prescribed, or contact the pharmacist to see if an emergency supply could be made available, to ensure that the resident received the medication that had been ordered. The DOC advised that resident #001 had received an order for a specified medication on a specified date and understood that it had not been processed until the next evening. Resident #001 had been sent back to the hospital and had received another prescription for the same medication. The DOC specified that the pharmacy would not have received the faxed copies of the prescription until the Monday morning. The DOC indicated being aware that resident #001 had not received the specified medication as ordered but had received another medication instead.

The licensee failed to ensure that a specified medication had been administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 31st day of October, 2018

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

Original report signed by the inspector.