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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 12, 2018	2018_617148_0005	013493-17, 022167-17, 023041-17, 025490-17	Critical Incident System

Licensee/Titulaire de permis

Dundas Manor Limited
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

Dundas Manor Nursing Home
533 Clarence Street P.O. Box 970 WINCHESTER ON K0C 2K0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 23, 26 and 27, 2018

This inspection included four critical incidents; Log 013493-17 related to a medication administration error, Log 022167-17 and 023041-17 related to incompetent/improper care and Log 025490-17 related to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Associate Director of Care (ADOC), Pharmacist, Nutritional Manager, Cooks, Food Service Workers, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition, the Inspector reviewed identified resident health care records, various documents and policies related to the medication management system, the licensee's policy to promote zero tolerance of abuse and neglect along with abuse/neglect staff training material. The Inspector also observed staff and resident interaction, the resident's environment, areas related to the acquisition and dispensing of medications and meal service.

The following Inspection Protocols were used during this inspection:
Dining Observation
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 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 :

The licensee failed to ensure that a drug was administered to a resident in accordance with the directions for use specified by the prescriber.

A critical incident was submitted to the Director on a specified date, describing a medication incident whereby a resident did not receive a physician ordered medication. On a specified date, resident #002 returned from hospital with a specified diagnosis; included in the hospital discharge care plan was the administration of specified drug for the next five days. This drug was reconciled upon returned to the home whereby the attending physician authorized the drug to continue and the reconciliation form was faxed to the home's pharmacy service provider. Records from the pharmacy provider indicated that the physician order for the identified drug was processed and delivered to the home on the same evening. It is the process that the pharmacy provider input each drug order received into the resident's electronic Medication Administration Record (eMAR). The eMAR for the specified month was reviewed does not indicate the inclusion of the identified medication and in this way there is no record to support that the resident was provided with the medication as prescribed.

This was discovered nine days after the physician order, when RN #104 reviewed the medication administration records and noted that the identified drug had not been administered. The lead for the home's investigation into this incident was the home's Associate Director of Care (ADOC). The ADOC indicated that the investigation concluded that the pharmacy provider had not entered the identified drug into the eMAR and in this way staff were not aware of the need to administer the medication.

Resident #002 did not receive a five day treatment of an identified drug as prescribed. (Log 013493-17)

Issued on this 12th day of March, 2018

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

Original report signed by the inspector.