Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2020	2020_821640_0005	022646-19	Complaint

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South BRAMPTON ON L6Y 5A7

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

Faith Manor Nursing Home
7900 Mclaughlin Road South BRAMPTON ON L6Y 5A7

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

HEATHER PRESTON (640)

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 21, 22 and 23, 2020.

During the course of the inspection, the LTCH Inspector toured the home, observed the provision of care, conducted interviews, reviewed clinical records and policy and procedures.

The following complaint intakes were reviewed:

Complaint #IL-72426-19, log #022646-19 related to pain management.

During the course of the inspection, the inspector(s) spoke with resident families, Registered Practical Nurses (RPN), Registered Nurses (RN) and the Director of Care (DOC).

The following Inspection Protocols were used during this inspection:
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	Légende 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 were administered to residents #001and #003

in accordance with the directions for use as specified by the prescriber.

i) The Ministry of Long-Term Care (MLTC) received a complaint regarding pain management for resident #001. They were receiving specialized care and treatment.

Resident #001 was placed on specialized care and treatment and were receiving specific intermittent medication as needed (prn).

The licensee's policy "Medication Administration" with a last revision date of July 1, 2018, directed staff to accurately transcribe the medication order onto the medication administration record (MAR) and administer medications in a timely manner.

The Long-Term Care Homes (LTCH) Inspector reviewed the clinical record, specifically the “LTC Prescriber’s Order Form”, the medication administration record (MAR) and the progress notes.

On an identified date in August 2019 at a specific time, the Nurse Practitioner (NP) prescribed a routine order of a specific medication to be given routinely every three hours.

The MAR was reviewed by the LTCH Inspector and the resident had been administered their prn medication at a specific time of day. The routine order was not implemented for over eight hours later when it was to be given three hours from the last prn dose.

RPN #100 said they had not implemented the medication order until they had received the MAR from pharmacy with an implementation time which was determined by pharmacy.

The Director of Care (DOC) said that with a change in a medication administration order for a high-risk medication, it was an expectation that the order be implemented immediately as prescribed. They said the first dose of the new routine medication order was to have been administered three hours following the last prn dose of that medication.

The DOC acknowledged that resident #001 had not been administered two doses as prescribed.

ii) Resident #003 was placed on specialized care and treatment with specific orders in

place. They were receiving intermittent prn medication.

The LTCH Inspector reviewed the clinical record, specifically the “LTC Prescriber’s Order Form”, the MAR and the progress notes.

On an identified date in November 2019 at a specific time, the Nurse Practitioner (NP) prescribed a routine order of the medication to be given every four hours.

The MAR was reviewed by the LTCH Inspector and the resident had been administered their prn medication at a specific time and the routine order of the medication was not implemented for seven hours.

RPN #100 said they had not implemented the medication order until they had received the MAR from pharmacy with an implementation time which was determined by pharmacy.

The DOC said the first dose of the new routine order for the medication was expected to have been administered four hours following the last prn dose of the medication.

The DOC acknowledged that resident #003 had not been administered one dose of their specific medication as prescribed.

The licensee failed to ensure that residents #001 and #003 were administered their medication as 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 the licensee must ensure that drugs are administered to residents in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

Issued on this 31st day of January, 2020

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

Original report signed by the inspector.