Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 6, 2023
Inspection Number: 2023-1319-0003
Inspection Type: Complaint Critical Incident System
Licensee: 0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership
Long Term Care Home and City: Forest Hill, Kanata

Lead Inspector	**Inspector Digital Signature**
Emily Prior (732)	Emily Prior Digitally signed by Emily Prior Date: 2023.07.06 13:48:31 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 28, 29, 2023 and July 4, 2023

The following intake(s) were inspected:

- Intake #00088488 - Complaint related to medication administration and continence care
- Intake #00090624 - CIR 2834-000009-23 related to falls prevention and management

The following **Inspection Protocols** were used during this inspection:

Continence Care
Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 1.

The licensee has failed to ensure that toileting, as set out in a resident's plan of care, was documented.

Rationale and Summary:
A resident required two staff assist with toileting for frequent incontinence of bladder and bowels. Toileting is to be documented at a minimum once a shift on Point Of Care (POC).

POC Personal Support Worker (PSW) documentation was reviewed for the month of May, 2023. Blank spaces were noted on one evening shift and six night shifts.

The Director of Care (DOC) confirmed that a blank space indicated staff did not document care.

There is risk of residents receiving inconsistent and improper continence care by not ensuring residents toileting care is documented.

Sources: resident's plan of care; Point of Care Documentation May 2023; interview with DOC, ADOC, and PSW #100.
[732]

WRITTEN NOTIFICATION: Medication Management System

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to ensure that the written policies developed for the medication management system to ensure the accurate administration of drugs was implemented.

Rationale and Summary:
The licensee's policy on ordering medications specified that when a registered staff processes the prescriber's orders, ensure the order is accurately transcribed to the Medication Administration Record

(MAR). The registered staff is to sign and date Nurse Check #1 on prescriber's order after transmission of order to pharmacy is verified and MAR to original prescriber's order is checked.

A resident had received an order from the hospital on a specified date for an ointment to be applied every night at bedtime, to a specific eye, for one month. The order was transcribed to the electronic MAR by a Registered Nurse (RN) the next day as ointment to be applied to the other eye, every night at bedtime, for one month.

The RN confirmed that they had written the wrong eye down when transcribing the resident's medication order. As a result, the resident received ointment to the wrong eye for three doses.

There was risk of harm to the resident's health as a result of the transcription error.

Sources: resident's electronic MAR and medication orders; Medication Incident Report; Care RX Pharmacy Policy and Procedure Manual for LTC Homes. Ordering Medications, Policy 4-2-1, revised 9/19; interview with an RN, DOC, and other staff.
[732]

WRITTEN NOTIFICATION: Administration of Drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Rationale and Summary:
A resident was ordered an ointment to be applied every night at bedtime, to a specific eye, for one month. The medication order was transcribed incorrectly, indicating to apply the ointment to the other eye. As a result of the error, the resident received the ointment to the wrong eye for three days.

As a result of not administering the resident's medication to the correct eye, there was risk of the affected eye worsening.

Sources: resident's electronic MAR and medication orders; Medication Incident Report completed; progress notes; and interview with DOC, and other staff.
[732]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary:
Registered staff are to complete a Medication Incident Report online when a medication incident or adverse drug reaction has occurred, including near miss situations.

On a specified date an order for ointment to be applied every night at bedtime, to a specified eye, for one month, was transcribed incorrectly by an RN resulting in the resident receiving the ointment to the wrong eye for three doses.

Upon review of the resident's health care record, Inspector #732 was unable to locate a Medication Incident Report for the above medication incident. The DOC indicated that one should have been completed and the RN who made the transcription error confirmed that they had not completed a Medication Incident Report at the time.

There is risk of repeat medication incidents occurring by not completing a Medication Incident Report as corrective actions and reviews cannot be completed for the incident.

Sources: resident's electronic MAR and medication orders; Medication Incident Report; Care RX Pharmacy Policy and Procedure Manual for LTC Homes. Ordering Medications, Policy 4-2-1, revised 9/19; Care RX Pharmacy Policy and Procedure Manual for LTCH Homes. Medication Incident Reporting, Policy 9-1, revised 06/20; progress notes; and interview with DOC, RN, and other staff.
[732]

Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559