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
Feb 6, 2015	2015_295556_0003	O-000979-14, O-001294-14	Critical Incident System

Licensee/Titulaire de permis

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST UNIT 12 PETERBOROUGH ON K9K 2M9

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

WENDY PATTERSON (556)

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): January 21, 22, and 23, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Care Coordinator (CCC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Pharmacist.

The Inspector also reviewed resident's health care records, internal investigation documentation, internal incident reports, and medication policies #9-1, #3-6, #4-11, #3-12, #3-2-2.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

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 :

1. The licensee failed to ensure that drugs were administered to residents #001, and #002 in accordance with the directions for use specified by the prescriber.

As part of a critical incident inspection Inspector #556 reviewed the critical incident report submitted to the MOHLTC by the home. The report stated that on a specific date Resident #002 was noted to be very lethargic and not maintaining his/her posture in the wheelchair, and it was noted on the resident's medication administration record (MAR) that Resident #002 had received 0.5mg instead of 0.25mg of a specific drug the evening before.

A review of the physician's orders on Resident #002's health care record indicated that on a specific date the physician ordered 0.5mg of the medication at bedtime, to start in two weeks time. An additional order prescribed 0.25mg of the same medication at bedtime until the 0.5mg dosage was started.

In an interview RN #103 reviewed the physician's orders and stated that Resident #002 was to be administered 0.25mg of the medication on three consecutive evenings and then the 0.5mg dosage was to start on the fourth evening.

In an interview the Clinical Care Coordinator (CCC) stated that she completed the investigation into the medication incident. Stated that the nurse working on evening three of the specific time frame administered 0.5mg of the medication to Resident #002, which was the incorrect dosage. The CCC further stated that there is no evidence that Resident #002 was confused, lethargic, or having difficulty holding his/her posture prior to receiving the 0.5mg dosage but these symptoms were evident the following morning.

The home's medication incident report indicated that a dispensing error had taken place and stated that the correct dosage of the specific medication as prescribed for Resident #002 was 0.25mg daily for 3 days and then 0.5mg daily. The report further stated that Resident #002 was administered 0.25mg for 2 days and then the 0.5mg dosage was administered to the resident, one day earlier than prescribed. The report described the effect of the medication on Resident #002 as confusion, overly sedated, and leaning over to the left side. The physician was notified and the medication was discontinued.

In an interview the Director of Care (DOC) stated that it was established that Resident #002 had a sensitivity to the specific medication and therefore the drug was discontinued. [s. 131. (2)]

2. As part of the inspection Inspector #556 reviewed a second critical incident report submitted to the MOHLTC by the home, the report stated that Resident #001 did not

receive his/her ordered medication for 8 consecutive days and that a medication error involving a high risk medication had occurred.

A review of the progress notes in Resident #001's health care record indicated that on a specified date Resident #001 had not received his/her medication since 8 days previous.

In an interview RPN #101 stated that Resident #001 was admitted to the home a few years ago with a specific diagnosis and receiving a high risk medication. #101 further stated that when she returned to work on a specific evening, after being on vacation for a week, she noticed that Resident #001's medication was no longer appearing on the medication administration record (MAR), which is what prompts and directs the nurses to administer medication. #101 reviewed the physician's orders and determined that the Physician had not discontinued the medication. #101 then left a message for the nurse to follow up on the following day since it was already late in the evening.

In an interview RPN #102 stated on a specific day she found a note left by the nurse who had worked the previous evening questioning why Resident #001's medication had been discontinued on the MAR. #102 reviewed the physician's orders and verified that the medication had not been discontinued. She then notified a nursing manager and the pharmacy to advise them that the medication had been discontinued from Resident #001's MAR but had not been discontinued by the Physician.

In an interview the DOC stated that when the full time RPN came back to work after being away on a one week vacation she found it odd that Resident #001's medication had been discontinued, especially since it was a large dose and the resident had been on it for a long time. The DOC further stated that because Resident #001 was noticeably lethargic, which was noted by the POA, and the Physiotherapist, the home considered the incident to be a medication error with adverse effect. [s. 131. (2)]

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

Issued on this 6th day of February, 2015

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

Original report signed by the inspector.