

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007 Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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, K1S-3J4 Telephone: (613) 569-5602 Facsimile: (613) 569-9670 Bureau régional de services d'Ottawa 347, rue Preston, 4iém étage OTTAWA, ON, K1S-3J4 Téléphone: (613) 569-5602 Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 12, 16, 17, 23, 2012	2012_030150_0013	Complaint

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Clinical Coordinator, Registered Practical Nurses (RPN) and the resident.

During the course of the inspection, the inspector(s) reviewed resident's health records, the home's investigation report related to the incident, the lab book, interviewed staff and observed the resident's activities.

The following Inspection Protocols were used during this inspection: Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES		
Legend	Legendé	
VPC – Voluntary Plan of Correction DR – Director Referral	<ul> <li>WN – Avis écrit</li> <li>VPC – Plan de redressement volontaire</li> <li>DR – Aiguillage au directeur</li> <li>CO – Ordre de conformité</li> <li>WAO – Ordres : travaux et activités</li> </ul>	



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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)	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

## Specifically failed to comply with the following subsections:

## s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

## Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 S.O.2007, c.8, s. 6(7) in that the care set out in the plan of care related to anticonvulsant medication level monitoring to be done every 2 weeks was not provided to the resident as specified in the plan.

The resident's doctor's order in March 2011, indicated that the medication level to be checked every 2 weeks.

The resident's chart indicates that there was no medication level done from May 2011 to October 2011.

On a specific date in October 2011, clinical condition of the resident deteriorated and the resident was transferred to the hospital.

On a specific date in October 2012, the resident was re-admitted from hospital with a diagnosis of anticonvulsant medication toxicity.

The home's investigation report indicates that an order for bi-weekly anticonvulsant medication levels was in place while the resident was living on one of the floor but the information was not transferred to the lab book on the other floor when the resident was transferred.

## Issued on this 24th day of July, 2012

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