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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 25, 2019	2019_785732_0032	015165-19	Complaint

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Garden Terrace
100 Aird Place KANATA ON P4R 0A6

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

EMILY BROOKS (732)

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): October 18, 2019 and October 21 - 23, 2019

Log #015165-19, related to plan of care, and hospitalization and change in condition, was inspected during this Complaint inspection

During the course of the inspection, the inspector(s) spoke with the Administrator, a Director of Care (DOC), and Registered Practical Nurses (RPN)

The inspector reviewed resident health care records and a complaint response letter; as well as staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication

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 has failed to ensure that a drug was administered to resident #001 in accordance with the directions for use specified by the prescriber.

A complaint letter was submitted to the Director describing the inappropriate treatment of resident #001's infection symptoms, resulting in a diagnosis of a specified infection. In the letter, it described that a medication was prescribed for seven days but was given for fourteen.

Inspector reviewed resident #001's physician orders. On a specified date, an order was written for a medication of a specified dosage to be given by mouth, twice a day, for seven days. Review of resident #001's progress notes indicated that on a specified date, RPN #100 discovered resident #001's medication order was transcribed by pharmacy for fourteen days and not seven days. Inspector reviewed resident #001's electronic medication administration record (eMAR) for a specified month. Resident #001 received their first dose of the medication on a specified date at a specified time, and their last dose of the medication on a specified date at a specified time, indicating resident #001 received the medication for an additional six days than prescribed.

Director of Care #103 indicated to Inspector #732 that resident #001 received the medication for longer than prescribed and that the error was due to an unclear transmission of the medication order to pharmacy. [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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of October, 2019

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

Original report signed by the inspector.