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

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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 13, 2018	2018_505103_0017	010954-18	Resident Quality Inspection

Licensee/Titulaire de permis

Land O'Lakes Community Services
12497A Highway 41 PO Box 92 Northbrook ON K0H 2G0

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

Pine Meadow Nursing Home
124 Lloyd Street P.O. Box 100 Northbrook ON K0H 2G0

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

DARLENE MURPHY (103), CATHI KERR (641)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 5-8, 11, 2018.

The following critical incidents were inspected during the Resident Quality Inspection:
Log #011162-18 (CIS #2796-000005-18)-controlled substance missing/unaccounted,
Log #011829-18 (CIS #2796-000006-18)-resident fall with injury.

During the course of the inspection, the inspector(s) spoke with residents, family members, Resident Council President, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Resident Program Manager, RAI Coordinator, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) conducted a walking tour of the resident home areas, reviewed resident health care records, observed infection control practices, medication administration, and medication storage areas.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

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	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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

During an interview with Inspector #641 on June 8, 2018, the DOC reviewed a medication incident involving resident #024 and resident #009 with the Inspector.

The DOC stated this incident had occurred during the night shift with Registered Nurse (RN) #111. Resident #009 had been ordered a specified medication. When the RN went to give this to resident #009 at 0545 hours on a specified date, they gave the tablet to resident #024 in error. Resident #024 did not have an order for this specified medication and should not have received this medication. Resident #024 had been assessed at the time and there was no ill effect to the resident.

The licensee failed to ensure that resident #024 received medication that had been prescribed to the resident. [s. 131. (1)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #023 had a physician's order for a specified medication to be given twice daily. On an identified date, the physician changed the dosage of the specified medication.

RN #110 had processed the physician's order for the change in dosage but had not marked the resident's medication strip package to indicate the change. The same RN then gave resident #023 the incorrect dosage of the specified medication in error. Resident #023 had been assessed at the time and there was no ill effect to the resident.

The licensee failed to ensure that drugs were administered to resident #023 in accordance with the directions for use 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 to ensure no drug is used by or administered to a resident unless prescribed and that medications are administered in accordance with the direction for use specified by the prescriber, to be implemented voluntarily.

Issued on this 13th day of June, 2018

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

Original report signed by the inspector.