Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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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
Mar 15, Jun 1, 4, 5, 2012	2012_044161_0018	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

ROSEBRIDGE MANOR
131 Roses Bridge Road, R. R. #2, Jasper, ON, K0G-1G0

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

KATHLEEN SMID (161)

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 home's Administrator, Director of Care, a Registered Practical Nurse and an Ontario College of Nurses Practice Consultant.

During the course of the inspection, the inspector(s) reviewed a letter of complaint, resident's health record, home's Medication Pass Policy 4.8 and a Medication Incident Report.

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
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

The licensee failed to comply with O. Reg 79/10 s. 131 (3) in that the licensee did not ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On a date in December 2011 at the supper medication pass, Registered Practical Nurse (RPN) # S102 prepared the residents' medications and directed Personal Support Worker (PSW) # S103 to administer these medications to the residents.

On that date in December 2011 at the supper medication pass, PSW # S103 administered the medications the RPN # S102 had prepared.

On June 1, 2012, the inspector conducted a telephone interview with RPN # S102. The RPN # S102 stated that she poured the residents' medications passed them to PSW # S103 and directed PSW # S103 to administer the medications. The PSW # S103 administered the medications to the residents as directed by RPN # S102.

On June 1, 2012, the inspector and the home's Administrator discussed the incident in December 2011 whereby PSW # S103 had administered the supper medications to the residents as directed by RPN # S102. The Administrator indicated that PSW # S103 was also an RPN who worked a portion of her PSW shift on that date in December 2011 as an RPN during the supper medication pass.

On June 1, 2012 the inspector conducted a telephone interview with a Practice Consultant from the College of Nurses of Ontario. The Practice Consultant indicated that PSW # S103 received her temporary license as an RPN at a date later than when the incident occurred. Thus PSW # S103 was not a licensed RPN on the date in December 2011 when he/she administered the supper medications to residents.

2. The licensee failed to comply with O. Reg 79/10 s.131 (2) in that a drug was not administered to a resident in accordance with the directions for use specified by the prescriber.

On a date in October 2011, resident # 001 was prescribed Hydromorphone Contin 12 mg every 8 hours.

The following day in October 2011 resident # 001 received Hydromorphone Contin 12 mg at 08:00 hours and 4 hours later at 12:00.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following subsections:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s.135 (1) (a) in that a medication incident involving a resident occurred on October 25, 2011 and there is not a record of the immediate actions taken to assess and maintain the resident's health.

On a date in October 2011, resident # 001 was prescribed Hydromorphone Contin 12 mg every 8 hours.

The following day in October 2011 resident # 001 received Hydromorphone Contin 12 mg at 08:00 hours and 4 hours later at 12:00.

There is not a record of the immediate actions taken to assess and maintain the resident # 001's health upon discovery of the medication incident in October 2011.

Issued on this 8th day of June, 2012

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

Kathleen Smid