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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2015	2015_198117_0004	O-001587-15	Complaint

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
2 OVERLEA BLVD. TORONTO ON M4H 1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

LYNE DUCHESNE (117)

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): February 3 and 4,2015

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, RAI coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the Resident Care Coordinator, and the Registered Dietitian. The Inspector also reviewed of an identified resident's health care record, policies related to medication reconciliation and administration, as well as internal incident report.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Skin and Wound Care

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

Resident #1 was admitted to the home on a specific day in November 2014. The resident's medication orders were reviewed by the attending physician, reconciled and sent to the pharmacy for processing. The resident has a specific antidyskinetic medication that was not readily available at the pharmacy. The specific medication was delivered to the long term care home after the resident's other medication had been delivered.

Medication Administration Records (MAR) for Resident #1 document that the antidyskinetic medication was not administered on three consecutive days after the resident's admission, in November 2014. Chart documentation indicates that the medication error was identified on the morning of the 5th day of the resident's admission. The resident was immediately assessed and the attending physician notified of the medication error. Resident #1 did not present with any adverse effects. Resident #1's Power of Attorney was also notified of the medication error in which the resident had not received his/her prescribed medication as per medical orders. It is noted that Resident #1 did receive his/her prescribed antidyskinetic medication on the day the error was identified in November 2014. On February 3, 2014, the DOC and RPN S#104 confirmed the medication error and actions taken by the home once the error was identified.

On February 4, 2014, the home's DOC stated to the Inspector that the home and pharmacy did investigate the cause of the medication error. Although the antidyskinetic medication was delivered to the home, the medication was not correctly entered by the pharmacy into the home's Electronic Medication Administration Record (eMAR). The medication did not show up on Resident #1's prescribed medication list and eMAR. Post-delivery of the antidyskinetic medication, nursing staff did not identify this error during medication verification. As such nursing staff did not know that the specific medication was to be administered.

Resident #1 was not administered his/her prescribed antidyskinetic medication on three consecutive days in November 2014. [s. 131. (2)]

Issued on this 5th day of February, 2015

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

Original report signed by the inspector.