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 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**
Jul 23, 24, 25, 26, 30, 31, 2012	2012_041103_0029	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY, PICTON, ON, K0K-2T0

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

DARLENE MURPHY (103)

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 Registered Nurses, Registered Practical Nurses, Pharmacists, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records. This complaint inspection is Log O-000855-12.

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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

The licensee failed to comply with O. Regs 79/10 s.134 (a) whereby the licensee failed to ensure there was monitoring and documentation of the resident's response and effectiveness of the drug appropriate to the risk of the drug.

Resident #1 was being treated for uncontrolled pain. The attending physician consulted with a specialist and prescribed an identified medication to address Resident #1's pain. The medication was given daily for a period of seventeen days.

Throughout the course of the medication, the resident developed multiple open and inflamed areas and the resident's condition deteriorated.

The resident began complaining of feeling unwell and was noted to have a sore and reddened mouth with green mucous evident. The resident continued to feel unwell and began expectorating moderate amounts of yellow mucous.

Resident #1's skin condition continued to deteriorate and some areas were noted to be large, open and bleeding. The physician ordered a treatment for the presence of thrush in the resident's mouth and prescription ointment for the resident's wounds.

The resident's appetite and fluid intake was poor due to the condition of his/her mouth. Over the next several days, the resident became lethargic and was eventually placed on isolation for a possible respiratory infection. Resident #1 was then noted to be febrile. The resident was encouraged by staff to go to hospital and finally agreed later that day.

The resident deceased five days later. An autopsy was done and the cause of death was determined as an overdose of the identified medication.

The prescribing physician faxed to the home a guideline for the prescription and monitoring of the identified medication in addition to the initial order for the identified medication. This guideline included the side effects for the medication as follows: mouth ulcers, sore throat, drowsiness, fever, any unexplained illness or infection, epistaxis or unexplained bruising/bleeding. This guideline was received by the home and placed directly with the physician orders and was not viewed by the registered staff administering the medication. The guideline also made mention to the usual dose of the identified medication.

Registered Practical Nurses, S102 and S103 were interviewed. Both had administered the medication to Resident #1 at some point during the course of the treatment. Neither staff recall ever giving this medication prior to this and neither were familiar with the side effects of the medication. The staff stated they could not recall researching the side effects of medication. In addition, the staff were not able to identify the side effects being exhibited by Resident #1 as side effects that related to the medication.

Issued on this 31st day of July, 2012

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