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
Dec 17, 2018	2018_702197_0027	032228-18	Resident Quality Inspection

Licensee/Titulaire de permis

Deem Management Limited
2 Queen Street East Suite 1500 TORONTO ON M5C 3G5

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

Wellington House Nursing Home
990 Edward Street North P.O. Box 1510 PRESCOTT ON K0E 1T0

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

JESSICA PATTISON (197), WENDY BROWN (602)

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): December 10-13, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeeping staff, residents and family members.

The inspectors also observed resident care and medication administration and reviewed resident health care records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Residents' Council

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	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 medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A specified medication was prescribed for resident #021, to be given by mouth (PO), three times daily. On a particular date, RN #104 failed to administer this medication to resident #021 at one of the specified administration times. The error was discovered the same day and the resident was monitored overnight with no documented adverse effects.

During an interview with Inspector #602, on December 12, 2018, the Director of Care (DOC) #100 indicated that the RN forgot to administer the medication as they got distracted by events on the unit. RN #104 is now consistently using electronic Medication Administration Record (eMAR) colour code system to ensure all medications are given at prescribed time and double checking this at the end of each shift. In addition, the home's pharmacy provider recently gave a presentation for registered staff on medication incidents and reporting.

The licensee failed to ensure that a medication was administered to resident #021 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 17th day of December, 2018

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

Original report signed by the inspector.