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
Mar 21, 2019	2019_717531_0004	029340-18	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

West Lake Terrace
1673 County Road, #12, R. R. #1 PICTON ON K0K 2T0

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 27, 28, March 4, 5, 6 and 7, 2019.

Log #: 029340-18 Critical Incident Report #0997-000007-18 related to the medication management system.

During the course of the inspection, the inspector(s) spoke with the Administrator, the RAI-Coordinator (RC), Registered Practical Nurses (RPN), and Registered Nurses
The inspector conducted a walking tour of the home, reviewed resident health care records, observed resident care and services, observed the medication management system including the medication accountability and administration documentation records of controlled substance and reviewed medication policy and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication

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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of a missing or unaccounted for controlled substance no later than one business day.

Critical Incident System (CIS) report #0997-000007-18 was submitted to the Ministry of Health and Long Term Care.

The CIS report read, that on a specified date and time it was noted a medication was missing from resident #001's narcotic dispensing package. The physician order on the narcotic dispensing card read the medication to be administered by mouth three times a day as required. The resident last dose was indicated for a specified date and time. The documented narcotic accountability and administration record supported the tablets remaining until it was noted on a specified date that one dose (1/2 tab) of the medication was unaccounted for. The incident was immediately reported, investigation initiated and it was determined on a specified date that the medication was unaccounted for.

On March 6, 2019 during an interview with the Administrator and review of the critical incident report, which was submitted to the Director on a specified date the Administrator told inspector #531 they created the report on a specified date however did not realize that they had not submitted the report at that time. The Director was notified twelve days after the incident.

The Director was not notified within one business day after the incident. [s. 107. (3)]

2. The licensee has failed to ensure that a written report was submitted to the Director within ten business days of becoming aware of a missing or unaccounted for controlled substance.

On a specified date Critical Incident System (CIS) report #0997-000007-18 was submitted to the Ministry of Health and Long Term Care Director, which read that the licensee was made aware of the incident on a specified date.

On March 6, 2019 during an interview with the Administrator and review of the written critical incident report, which was submitted to the Director on a specified date, the Administrator told inspector #531 they created the report on a specified date however did not realize that they had not submitted the report at that time. The written report to the Director was submitted twelve days after the incident.

The written report was not submitted to the Director within 10 days of becoming aware of the incident. [s. 107. (4) 1.]

Issued on this 23rd day of March, 2019

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

Original report signed by the inspector.