Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Dates of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
January 24, 25 and 26, 2011	2011_188_9619_21Jan152307	Complaint Log # S-00525, IL- 15007-SU

Licensee/Titulaire
Corporation of the Town of Kirkland Lake,
3 Kirkland Street West, Postal Bag 1757, Kirkland Lake, ON, P2N 3P4, Fax: 705-567-3535

Long-Term Care Home/Foyer de soins de longue durée
Teck Pioneer Residence
154A Government Road East, Postal Bag Service 3800, Kirkland Lake, ON, P2N3P4, Fax:705-567-3737

Name of Inspector/Nom de l'inspecteur
Melissa Chisholm 188

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the Assistant Director of Care (ADOC), Registered Nursing staff, Personal Support Workers (PSWs), the RAI coordinator, various residents currently residing in the home and family members of residents currently residing in the home.

During the course of the inspection, the inspector: Conducted a walk-through of all resident home areas and various common areas, observed the care of various residents currently residing in the home, observed medication passes, observed and tested the resident-staff communication and response system and reviewed the following:

- Policies and procedures related to the resident-staff communication and response system
- Health care records of current and discharged residents

The following Inspection Protocols were used during this inspection:
Safe and Secure Home
Medication Inspection

Findings of Non-Compliance were found during this inspection. The following action was taken:

1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O.Reg. 79/10, 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.

Findings:

1. Inspector reviewed 16 medication incident reports from 2010 involving residents. Of the documented medication incidents the inspector noted the following:
   - Seven of the medication incident reports relating to residents with an identified substitute decision-maker (SDM) have the section for "family notified" on these reports blank.
   - Two of the medication incident reports relating to resident with an identified SDM have "no" written in the "family notified" section with no further explanation as to why.
   - Four of the medication incident reports have the "no" written in the "physician notified" section with no further explanation as to why.
   - Seven of the medication incident reports have the "physician notified" section blank.

   The licensee failed to notify the resident, the resident's substitute decision-maker and the resident's attending physician or the registered nurse in the extended class following every medication incident involving a resident.
2. Inspector reviewed 16 medication incident reports from 2010. Inspector found no indication on any of the reports that the pharmacy service provider has been informed. The ADOC informed the inspector on January 25, 2011 that the pharmacy is not notified of every medication incident and continued to say the pharmacy is only notified if a medication incident involves the pharmacy directly. The licensee failed to notify the pharmacy service provider of every medication incident involving a resident.

Inspector ID #:	188

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Feb 1st, 2011