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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 7, 2013	2013_128138_0017	O-00186-13	Critical Incident System

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY
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

PAULA MACDONALD (138)

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): April 17, 18 and 22, 2013

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, RAI Coordinator, Registered Practical Nurses (RPN), Personal Care Workers (PSW), Director of Life Enrichment, a Life Enrichment staff member, and a resident.

During the course of the inspection, the inspector(s) reviewed resident health records, reviewed the home's policy on falls prevention and management, reviewed Critical Incident Reports, observed a resident, and toured a resident's room.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 131. (1) in that the licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During a review of a resident's health record, it was noted that a progress note entry indicated that a resident received a medication for agitation and yelling. The electronic Medication Administration Record (eMAR) for this resident had been previously reviewed and it was noted that this medication was not listed for this resident. The resident's eMAR was reviewed with the unit RPN who confirmed that the resident is not planned to receive this medication and who could not explain why the resident would have received this medication. The resident's heath care record was further reviewed and no physician's order for the medication was found.

The incident was discussed with the Director of Care. The Director of Care stated that she was aware there was an incident in which the resident's health care record indicated that the resident received a medication with no corresponding physician's order. At the time of the inspection, the Director of Care stated that she had no explanation for the incident but that the home planned to complete their own internal investigation. An internal investigation has not yet been completed. [s. 131. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 7th day of May, 2013

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