Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére 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**
**Division de la responsabilisation et de la performance du système de santé**
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**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Jan 24, 31, Feb 1, 2, 3, 2012 | 2012_029134_0001 | Complaint |

**Licensee/Titulaire de permis**

OMNI HEALTH CARE LIMITED PARTNERSHIP
1840 LANSDOWNE STREET WEST, UNIT 12, PETERBOROUGH, ON, K9K-2M9

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

ALMONTE COUNTRY HAVEN
333 COUNTRY STREET, P.O. BOX 250, ALMONTE, ON, K0A-1A0

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

COLETTE ASSELIN (134)

## 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 the Director of Care, a Registered Nurse (RN), three Registered Practical Nurses (RPN, and one identified Resident.**

**During the course of the inspection the inspector conducted two complaint inspections log # O-002502-11 and O-02633-11**

**During the course of the inspection, the inspector(s) reviewed two identified Resident #1 and Resident #2's Health Records and the Licensee's Policy on Reporting and Investigation of a Medication Error by Staff.**

**The following Inspection Protocols were used during this inspection:**

**Medication**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 subsections:**

**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 following findings show the licensee did not comply with s. 131 (2) of the O. Reg 79/10 related to the administration of prescribed drugs.

The November 2011, Medication Administration Records (MARS) for Resident #2 were reviewed. There is a note in the right hand corner of this resident's MARS specifying to crush the resident's pills in apple sauce.

In November, 2011 Resident #2's SDM had found one large white pill as well as three other pills on the resident's bedroom floor. The home's internal investigation notes were reviewed. There is an entry indicating that the day shift RPN had reported having given Resident #2's medication with food at lunch and that perhaps the resident had spit them out after. The pills had not been crushed as per the direction provided on the MARS making it difficult for the resident to swallow.

The January 2012's MARS for Resident #2 were reviewed. It is to be noted that there are approximately 12 mornings were this resident did not receive the 07:00 and 08:00 medications as ordered. According to the code (2) entered in the MARS, the drug was refused. No measures or actions were taken to ensure the resident would take the prescribed morning medication and no change of orders was received.

Log # O-002502-11

In November, 2011, Resident #1 was administered the wrong medication.

The nurse was interviewed and reported to the inspector that the wrong medication was grabbed by error and that the MARS sheet was not verified for the name, dosage and time of administration before administering the medication. The medication was later signed for on the medication administration record sheet, indicating the resident had received the right medication.

Log # O-002633-11

*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 drugs are administered to residents in accordance with the directions for use specified by the physician, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following subsections:**

**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. O. Reg. 79/10, s. 135 (1).**

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;**
**(b) corrective action is taken as necessary; and**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to comply with section 135 (1) (a) and (2) (a) (b) and (c) of the O. Reg 79/10 in that, a medication incident involving Resident # 1 was not documented together with a record of the immediate actions taken to assess and maintain resident's health.

In November, 2011, Resident #1 was given the wrong medication. The progress notes were reviewed and there was no further assessment or follow-up documentation completed on Resident #1's condition as a result of the medication error which occurred on day shift.

2. The licensee has failed to comply with section 135 (2) (a), (b) and (c) in that, the medication incident involving Resident #1 was not documented, reviewed and analyzed.

The home has a policy on reporting and investigating of medication errors by staff. The "Resident Incident Report" was not completed as per the home's policy # 7.2.

In November, 2011, there was a medication incident involving Resident #1. This medication incident was not documented, reviewed and analyzed as per home policy. The factors which contributed to the error were not identified and there is no indication on how the home is planning to ensure that corrective action has been taken to prevent further recurrence.

Log # O-002633-11

***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 every medication incident involving a resident is documented together with a record of the immediate actions taken to assess and maintain the resident's health as well as to ensure that all medication incidents are reviewed and analyzed and corrective actions are taken as necessary, to be implemented voluntarily.***

**Issued on this 3rd day of February, 2012**

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

Colette Asselin, LTCH Inspector # 134