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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 18, 2018	2018_520622_0015	013796-18	Resident Quality Inspection

Licensee/Titulaire de permis

Broadview Nursing Centre Limited
210 Brockville Street Smiths Falls ON K7A 3Z4

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

Broadview Nursing Centre
210 Brockville Street Smiths Falls ON K7A 3Z4

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

HEATH HEFFERNAN (622), AMBER LAM (541)

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): June 19, 20, 21, 22, 2018

The following intakes were included in this inspection:

Critical Incident intake (CIS):

Log #008023-18 (CIS #2684-000004-18) and Log #009144-18 (CIS #2684-000005-18) related to falls with injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Associate Director of Nursing, the Food Service Manager, the RAI Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and family.

The inspectors also conducted a tour of the home, observed the administration of medication, reviewed medication incident documentation, reviewed policies related to medication administration, Professional Advisory Committee meeting minutes, an invitation for family members to a Family Council information session, the Residents' Council meeting minutes and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	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).

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On June 21, 2018, inspector #622 reviewed the risk management medication error report which indicated on a specified date, RPN #100 noted that resident #045 administered the wrong type of a specified medication. The resident's substitute decision maker and the physician were notified. The Physician gave direction to monitor resident #045 every two hours. There were no injuries or ill effect to resident #045 as a result of the incident.

On June 21, 2018, inspector #622 reviewed the electronic medication administration record (eMar) for a specified month which indicated resident #045 was prescribed a specified medication
During an interview with inspector #622 on June 21, 2018, Registered Practical Nurse (RPN)#100 stated on a specified date during the noon medication pass, they administered the wrong type of a specified medication in error to resident #045 rather than the prescribed medication.

During an interview with inspector #622 on June 21, 2018 at 1430 hours, Director of Nursing (DON) #102 stated resident #045 was administered specified medication which was not prescribed for them. [s. 131. (1)]

2. The Licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On June 21, 2018, inspector #622 reviewed the risk management medication error report which indicated on a specified date, Registered Nurse (RN) #101 observed that resident

#011’s specified treatment was dated applied on a specified date. RN #101 noted the specified treatment was scheduled to be changed on a specified date three days after application but had been omitted. The specified treatment dated a specified date was removed and a new one was applied one day late. Resident #011 and the physician were notified of the medication incident. No ill effect was noted to resident #011 from the medication incident.

On June 21, 2018 inspector #622 reviewed the eMar dated for a specified month which indicated resident #011 was prescribed a specified treatment, which was to be applied every 3 days and removed per schedule.

During an interview with inspector #622 on June 21, 2018, RN #101 stated on a specified date they noted the specified treatment on resident #011 was dated a specified date four days prior. The order indicated the specified treatment was to be changed every 3 days therefore it should have been changed on a specified date, three days after it was applied.

During an interview with inspector #622 on June 21, 2018, DON #102 stated RPN #104 missed applying the specified treatment on resident #011 on the specified date. DON #102 stated because the specified treatment was omitted on the specified due date, it was not administered according to directions from the prescriber. [s. 131. (2)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 1st day of August, 2018

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

Original report signed by the inspector.