



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
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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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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|--|---------------------------------------|------------------------|--|
| Dec 3, 2012 | 2012_179103_0018 | O-002260-12 | Critical Incident System |

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

BURNBRAE GARDENS LONG TERM CARE RESIDENCE
320 BURNBRAE ROAD EAST, P.O. BOX 1090, CAMPBELLFORD, ON, K0L-1L0

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

DARLENE MURPHY (103)

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): December 3, 2012

During the course of the inspection, the inspector(s) spoke with the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed resident health care records and the home's policies on medication administration.

The following Inspection Protocols were used during this inspection:

Medication



Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Table with 2 columns: Legend and Legendé. Legend includes WN (Written Notification), VPC (Voluntary Plan of Correction), DR (Director Referral), CO (Compliance Order), WAO (Work and Activity Order). Legendé includes Avis écrit, Plan de redressement volontaire, Aiguillage au directeur, Ordre de conformité, Ordres : travaux et activités. The main body of the table contains a detailed description of non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) and its French equivalent in the 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 :



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1. The licensee has failed to comply with O. Reg 79/10 s. 131 (1) whereby drugs were administered to residents that were not prescribed.

On October 13, 2012 during morning care, staff found an identified medication patch applied to Residents #1, #3, and #4 all hand dated October 13, 2012. These residents did not have a physician order for these medication patches. A short time later, Residents #2, #5 and #6, who have physician orders for an identified medication patch, were found with no patches in place. Registered staff S101 assessed the residents, and notified the physician. All residents were deemed stable with no untoward effects.

The home conducted a thorough investigation to ensure no additional medication errors had occurred. [s. 131. (1)]

Issued on this 3rd day of December, 2012

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

A handwritten signature in cursive script that reads "Darlene Murphy".