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

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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 21, 2019	2019_717531_0007	003739-19, 004042-19	Complaint

Licensee/Titulaire de permis

The Corporation of the County of Hastings
235 Pinnacle Street P.O.Bag 4400 BELLEVILLE ON K8N 3A9

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

Hastings Manor Home for the Aged
476 Dundas Street West P.O. Box 458 BELLEVILLE ON K8N 5B2

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

SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 13, 14 15 and 18, 2019.

Log #004042-19 related to medication administration
Log #003739-19 related to reporting and complaints

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Nursing (ADON), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), resident Substitute Decision Makers and residents.
During the course of the inspection the inspector conducted a walking tour of the home, reviewed resident health care records, observed resident care and services, reviewed medication administration practices, medication administration and written processes for handling of medication incidents and adverse drug reactions, reviewed reporting and complaint policy and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Reporting and Complaints

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	Légende 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 failed to ensure that no drug was administered to resident #001 unless the drug had been prescribed for the resident.

Inspector #531 reviewed resident #001's physician orders which indicated that resident #001 had been prescribed a medication treatment to be administered at 0730 hours.

Review of the incident report on a specified date RPN #110 had administered a co-resident's medication to resident #001 at 0730 hours.

On March 18, 2019 during an interview with the DOC and review of the medication incident report, the DOC indicated that on a specified date RPN #110 had administered a co-resident's medication treatment at 0730 hours, which was discovered at 2000 hours by RPN #113. The DOC indicated that when the incident was discovered, the resident was immediately assessed, the physician, the pharmacy and the resident's SDM were notified. Resident #001 was monitored and there were no untoward effects to resident #001.

The licensee failed to ensure that no drug was administered to resident #001 unless the drug had been prescribed for the resident. [s. 131. (1)]

2. The licensee has failed to ensure drugs were administered to resident #002 in accordance with the directions for use specified by the prescriber.

Inspector #531 reviewed resident #002's physician orders which indicated that the resident had been prescribed a medication treatment to be administered at 0730 and removed at 2000hours.

On March 18, 2019, during an interview with the DOC and review of the incident report, the DOC indicated that on a specified date, RPN #113 had discovered resident #002's medication treatment had not been administered by RPN #110 at 0730 hours . The DOC indicated that RPN #113 recognized the omission, assessed resident #002, notified the physician, pharmacy and the SDM and monitored the resident throughout the shift. The DOC indicated that there were no untoward effects to resident #002.

The licensee failed to ensure that drugs were administered to resident #002 in accordance with the directions for use specified by 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 drugs are administered to a resident in accordance with the directions for use specified by the prescriber and that no drug was administered to a resident unless the drug had been prescribed for the resident, to be implemented voluntarily.

Issued on this 23rd day of March, 2019

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

Original report signed by the inspector.