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
Oct 29, 2013	2013_102116_0043	T-2187-12	Complaint

Licensee/Titulaire de permis

THE GOVERNING COUNCIL OF THE SALVATION ARMY IN CANADA
2 OVERLEA BLVD, TORONTO, ON, M4H-1P4

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

ISABEL AND ARTHUR MEIGHEN MANOR
155 MILLWOOD ROAD, TORONTO, ON, M4S-1J6

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

SARAN DANIEL-DODD (116)

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): September 9, 11, 12, 13, 16, 19, 20, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Food Service Manager, Dietary Staff, Registered Staff, Personal Support Workers and Resident #1.

During the course of the inspection, the inspector(s) reviewed the health record of Resident #1, observed staff to resident interactions, medication incidents, education in-service documentation and the following home policies: skin care and medication administration.

The following Inspection Protocols were used during this inspection:
Medication

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 drugs were administered to Resident #1 in accordance with the directions for use specified by the prescriber on the following occurrences:

- As confirmed by record review and staff interviews, an identified Registered staff member failed to administer a scheduled medication to Resident #1 as directed by the prescribing physician.
- Resident #1 returned from hospital with orders to continue a medication. Interviews with staff members and review of the health record confirmed that the resident did not receive the prescribed medication for a specified period.
- A physician's order directed staff to administer a specified supplement to Resident #1. Review of the resident's health record and staff interviews confirmed that Resident #1 did not receive the supplement as prescribed over a specified period. Interviews with Registered staff members provided conflicting information regarding the availability of the supplement for Resident #1. One Registered staff member indicated the supplement was available for administration while, another Registered staff member reported the supplement was not available for administration therefore, unable to be administered [s. 131. (2)]

2. As confirmed by record review and staff interviews, on an identified date, a Registered staff member approached Resident #1 to remove a transdermal medication as ordered by the physician. Upon inspection, the Registered staff member noted the required dose of the transdermal medication was not applied to Resident #1 [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 Resident #1 in accordance with the directions specified by the prescriber, to be implemented voluntarily.

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:

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the Director of Nursing and Personal Care.

- On a specified date, a scheduled medication was not administered to Resident #1 as per the physician's order.
- Through record review and interviews held with Registered staff members and the Director of Care it was confirmed that the medication incident was not reported to the Director of Care [s. 135. (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 every medication incident involving Resident #1, to be implemented voluntarily.

Issued on this 12th day of November, 2013

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