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

Division de la responsabilisation et de la performance du système de santé
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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
May 2, 2014	2014_306510_0009	H-000512-13/H-000616	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF ERIN MEADOWS
2930 Erin Centre Boulevard, MISSISSAUGA, ON, L5M-7M4

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

IRENE PASEL (510)

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): April 25, 28, 29, 30, 2014

During the course of the inspection, the inspector(s) spoke with General Manager, Director of Nursing Care, Assistant Director of Nursing, Neighbourhood Coordinators, Registered Nurses, Registered Practical Nurses, Personal Support Workers

During the course of the inspection, the inspector(s) observed activity in neighbourhoods throughout the home, spoke with residents and family members and conducted record reviews

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication

Findings of Non-Compliance were found during this inspection.

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. (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 did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.
Incident A
• Medication incident report for an identified date in 2013, reported that Resident #1 received "existing insulin given on wrong time". Resident #1 received 22 units of Novorapid insulin at 0800 which should not have been given until 1700 hours on the identified date.
• Internal email on an identifed date in 2013 from Assistant Director of Nursing (ADON) to the Director of Nursing (DON)reported Resident #1 was administered the wrong dose of morning insulin.
• Registered staff #1 confirmed during interview that insulin was not given as prescribed.

Incident B
• Medication incident report dated August 2013 reported that Tylenol #2 was not given four times daily as prescribed to Resident #3 on an identified date in 2013. The error was discovered two days later when it was noticed during the narcotic count that there were too many tablets left.
• ADON and DON confirmed that two doses of Tylenol #2 were not administered to resident #3 as prescribed. The resident was not reported to experience increased pain.

Incident C
• Medication incident report for a specified date in 2013 reported that resident #4 did not receive three oral medications at noon as prescribed. The medications were found crushed, in the blister pack by the evening nurse. There were no negative outcomes for the resident.
• DON confirmed these medications were not given as prescribed. [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 drugs are administered to residents as directed by the prescriber, to be implemented voluntarily.

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Issued on this 21st day of May, 2014

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

Irene Pasel