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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 6, 2016	2016_270531_0010	011271-15	Complaint

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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 15, 16 and 17, 2016.

Log # 011271-15 related to care and services of a resident.

During the course of the inspection, the inspector(s) spoke with residents, resident substitute decision makers, Personal Support Workers, Registered Practical Nurses, Registered Nurses, Behavioural Support staff, the Nurse Practitioner, a unit manager, the Director of Care and the Administrator.
During the course of the inspection the inspector toured the home, observed resident care and services, reviewed resident health care records and appropriate policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Pain
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. (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 a drug was administered to resident #001 in accordance with the directions for use specified by the prescriber.

In reference to Log # 011271-15
Resident #001 is diagnosed with multiple comorbidities .

In an interview with resident #001 and his/her substitute decision maker (SDM) they indicated that on a specified date resident #001 had been prescribed a medication for a medical condition. The SDM told inspector #531 that the medication was placed on hold on a specified date as resident #001's condition had stabalized. Resident #001's SDM indicated that two months after the medication was placed on hold resident #001 was administered the medication in error as the medication order had been transcribed incorrectly.

Resident #001's health care records were reviewed for the specified dates and indicated the following:
-On a specified date the physician ordered the medication to be given weekly on Saturday.
-Three months later following an appointment with the physician he ordered the medication to be held.
-Review of the electronic medication administration records for the period the specified dates indicated that the order was transcribed as "hold medication for two months" .
-two months later resident #001 received the medication that was placed on hold.

On March 16, 2016 during an interview with RN #109 and review of resident #001's health record she confirmed that the order was transcribed incorrectly and as a result resident #001's medication was not administered to the resident in accordance with the directions specified by the prescribing physician.

Subsequently during an interview with the Acting Unit Manager and review of resident #001's health care records she confirmed for inspector #531 that the medication was not administered to resident #001 in accordance with the directions as specified by the prescribing physician. The Acting unit manager provided documentation to confirm that once the error was identified the Unit Manager investigated the incident and reviewed the error with the physician, employee and SDM. [s. 131. (2)]

Issued on this 6th day of April, 2016

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

Original report signed by the inspector.