Ontario

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 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
Aug 2, 2019	2019_648741_0018	010280-19, 013181-19	Complaint

Licensee/Titulaire de permis

peopleCare Inc.
735 Bridge Street West WATERLOO ON N2V 2H1

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

peopleCare Oakcrossing London
1242 Oakcrossing Road LONDON ON N6H 0G2

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

AYESHA SARATHY (741), SAMANTHA PERRY (740)

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): July 22-26, 2019

The following Complaints were inspected as a part of this inspection:

IL-68111-LO/ Log #013181-19 related to Cooling Requirements of the Home
IL-66973-LO/ Log #010280-19 related to Medication Administration Error

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RN), the Manager of Environmental Services, the Assistant Director of Resident Care (ADRC), the Executive Director (ED) and residents.

During the course of the inspection, the inspector(s) also reviewed clinical records for identified residents, observed residents and reviewed internal investigation notes relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Safe and Secure Home

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A. The home submitted a Critical Incident (CI) System report to the Ministry of Long-Term Care (MOLTC) related to a medication error, by which resident #001 was administered a non-prescribed drug.

Medications prescribed for resident #001 were reviewed on the electronic Medication Administration Record (eMAR). On a particular date, a medication incident report was documented in resident #001's clinical record. Specifically, it indicated that a staff member gave resident #001 another resident's medications in error. Review of orders for resident #001 in the electronic Treatment Administration Record (eTAR) indicated that an "incident follow-up note" was required to be completed by staff on every shift for 24-72 hours following the medication incident. The order also directed staff to document any adverse reactions to the medication.

B. The home submitted a CI report to the MOLTC, related to a medication error, by which resident #002 was administered a non-prescribed drug, resulting in an adverse drug reaction and hospitalization.

Medications prescribed for resident #002 were reviewed on the electronic Medication Administration Record (eMAR). On a particular date, a progress note in resident #002's clinical record documented, in part, that a staff member administered another resident's medications to resident #002 in error, resulting in an adverse drug reaction and hospitalization. Review of orders for resident #002 in the eTAR indicated that an "incident follow-up note" was required to be completed by staff on every shift for 24-72 hours following the medication incident. The order also directed staff to document any adverse reactions to the medication.

The licensee failed to ensure that no drug was used by or administered to residents #001 and #002 in the home unless the drug had been prescribed for them. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 2nd day of August, 2019

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

Original report signed by the inspector.