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
Jul 17, 2013	2013_225126_0010	O-000442-13	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BAY RIDGES
900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 19-20, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, one Registered Practical Nurse and the resident.

During the course of the inspection, the inspector(s) reviewed the resident health care record.

During this Inspection, the Inspector conducted one Critical Incident Inspection.

The following Inspection Protocols were used during this inspection:
Medication

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. (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 failed to comply with O. Reg 131. (1) in that the licensee did not ensure that drug administered to Resident #1 was prescribed to that resident.

On a specified evening shift in May,2013, Registered Practical Nurse S#100 prepared medications for two residents but both residents refused to take their medications at the time they were offered them and requested to take them later. Both medication cups were kept in the medication cart in different bins. When Resident #1 wanted to take her medications, S#100 administered Resident#2's medications to Resident's #1. Resident #1 was administered three different medications that were not prescribed by the physician.

Once S#100 realized the medication error, immediate action was taken that same evening, Resident #1 was made aware of the medication error and the physician and the family were notified. An order was received to transfer Resident #1 to the hospital. Resident #1 was kept in hospital for a few hours for monitoring and later returned to the home.

Interview with the Director of Care on June 18, 2013 indicated that S#100 was disciplined as per the home practices. [s. 131. (1)]

Issued on this 17th day of July, 2013

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