Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
May 7, 2021	2021_729615_0018	005134-21, 005439-21	Critical Incident System

Licensee/Titulaire de permis

Blue Water Rest Home
37792 Zurich-Hensall Rd RR #3 Zurich ON N0M 2T0

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

Blue Water Rest Home
37792 Zurich-Hensall Road, Lot 21, Hwy 84, R.R. #3 Zurich ON N0M 2T0

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

HELENE DESABRAIS (615)

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): May 4 and 5, 2021.

The following intakes were inspected during this inspection:

Log #005134-21/Critical Incident System (CIS) report #2987-000005-21, related to falls prevention:
Log #005439-21/CIS report #2987-000006-21, related to medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, a Registered Nurse-Charge Nurse, the Nurse Clinician-Infection Prevention and Control Lead, one Registered Practical Nurse and one Personal Support Worker.

The inspector also toured the home, observed Infection Prevention and Control practices, reviewed residents' clinical records, the home's Medication Administration policies and other relevant documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication

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. (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 :

The licensee has failed to ensure that a resident was administered a medication in accordance with the directions for use specified by the prescriber.

A review of the physician's order for a resident, indicated that the resident was to receive a specific medication dosage in the morning and the evening. A review of the resident's progress notes, Medication Administration Records and the home's Critical Incident System (CIS) report indicated that on 26 occasions, Registered Practical Nurse (RPN) did not administer the specific dosage to the resident. The RPN's failure to not administer the proper dosage of a medication to a resident posed minimal harm to the resident. During an interview, the Administrator stated that they expected all registered staff to follow a physician's order when administrating medication to residents.

Sources: a resident's clinical records, home's CIS submitted to the Ministry of Long Term-Care and staff interviews. [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 residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 7th day of May, 2021

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

Original report signed by the inspector.