Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 10th and 11th, 2011	2011_104_9522_10Mar082005	Complaint: O-000532

Licensee/Titulaire
Regional Municipality of Durham
605 Rossland Road East
Whitby, ON, L1N 6A3
Fax: 905-666-6221

Long-Term Care Home/Foyer de soins de longue durée
Fairview Lodge
632 Dundas Street West, P.O. Box 300
Whitby, ON, L1N 5S3
Fax: 905-668-8934

Name of Inspector(s)/Nom de l'inspecteur(s)
Judy Macaulay, Inspector-Nursing, #104

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to the concern of abnormal laboratory results of an identified resident.

During the course of the inspection, the inspector spoke with Assistant Administrator, the Director of Care, two registered nursing staff, Durham Regional police, and the resident.

During the course of the inspection, the inspector reviewed the identified resident's health record and observed their room, the medication storage area, the home's medication administration policy, the pharmacy provider manual, the narcotic count book, the discontinued drug supply, and several residents on the unit.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Medication

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

1 VPC
1 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with O. Reg. 79/10, s 8(1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,

(b) is complied with.

Findings:

1. Twenty three tablets of a specified medication were unaccounted for and not documented for the identified resident.
    - Thirty of thirty one tablets were noted punched out of this resident's medication card.
    - This resident's medication administration record was reviewed for three months.
    - Five doses were documented in the progress notes and on the medication administration record.
    - One dose of this medication was documented in the progress notes but not on the medication administration record.
    - One dose of this medication was documented on the medication administration record but not in the progress notes.
2. Twenty four tablets of a specified medication were unaccounted for and not documented for another identified resident.
    - Twenty five of thirty one tablets were noted punched out of this resident's medication card.
    - This resident's medication administration record was reviewed for six months.
    - One dose of this medication was documented on the medication administration record.
3. There is no documentation to indicate that these tablets were offered to, administered to, refused by these residents, or discarded.
4. There is no documentation to indicate that these tablets were borrowed from these residents' cards for other residents.
5. The Medication Administration Record policy NUR_04-04-26 (revised Feb 5, 2008), which stated that all medications which have been administered to a resident are documented on the resident's medication administration record, was not complied with.

Inspector ID #:	104

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 the home's Medication Administration Record policy, which states that all medications which have been administered to a resident are documented on the resident's medication administration record, is complied with. This plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. J Macaulay, LTCH Inspector-nursing
Title: Date:	Date of Report: March 31, 2011