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
Dec 20, 2013	2013_303563_0014	L-001024-13	Complaint

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

FOREST HEIGHTS
60 WESTHEIGHTS DRIVE, KITCHENER, ON, N2N-2A8

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

MELANIE NORTHEY (563)

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): December 18, 2013

During the course of the inspection, the inspector(s) spoke with the interim Administrator, the Director of Care, a Registered Practical Nurse, the Resident and the Resident's daughter.

During the course of the inspection, the inspector(s) made observations, reviewed health records, policies and other relevant documentation.

The following Inspection Protocols were used during this inspection: Medication

Findings of Non-Compliance were found during this inspection.

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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. 133. Drug record (ordering and receiving)

Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee failed to ensure the following information is recorded in respect of every drug that is ordered and received in the home: the prescription number, where applicable as evidenced by:

a) Management explained the expectation is to document the prescription number in the Drug Record Book on receipt of medication from pharmacy. The Resident had two prescriptions for the same medication. The absence of a prescription number on receipt of the medication created confusion for the pharmacy and for the family.

b) A staff member confirmed the prescription number was absent on the Drug Record Book form for receipt of the medication from pharmacy. The staff member also confirmed the prescription number should be documented when any drug is received by the home from pharmacy.

c) Management confirmed the prescription number was missing on receipt of the medication from pharmacy and the prescription number should be documented upon receipt of all drugs received from pharmacy according to the Ordering and Receiving Medication Policy 2.4.

d) The Ordering and Receiving Medication Policy 2.4 states, "The receiving nurse confirms the receipt of the correct medication and documents the following information in the appropriate spaces in the Drug Record Book: Prescription number of medication, where applicable. [s. 133.]

Issued on this 20th day of December, 2013

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

Melanie Northey