Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 13, 14, 2012	2012_049143_0046	Critical Incident

Licensee/Titulaire de permis

MANORCARE PARTNERS II
6257 Main Street, Stouffville, ON, L4A-4J3

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

FRIENDLY MANOR NURSING HOME
9756 County Road, #2, P.O. Box 305, DESERONTO, ON, K0K-1X0

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Administrator and the Director of Nursing

During the course of the inspection, the inspector(s) reviewed medication administration records, controlled drug tracking sheets, orientation checklist for Registered Nurse and College of Nurses of Ontario Report Form for Facility Operators and Employers.

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 subsections:

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 :

1. On a specified date a Registered Nurse (RN) was assigned the responsibility of administering medications and treatments. The RN documented on the Medication (MARS) and Treatment administration that medications had been administered and given as prescribed for Resident # 1-13 inclusive for this specified date. The Director of Nursing reported to the Ministry of Health and Long Term Care Inspector that on a specified date she completed an audit of the medication disposal envelope that is attached to the medication cart. The Director of Nursing found 98 pills and matched those pills to thirteen resident MARS. The Director of Nursing reported that 7 pills were unaccounted for, inclusive of a narcotic for resident # 9 as well as two other pills, three pills for Resident # 3 and one pill for resident # 13. The RN was interviewed and questioned on a specified date by the Director of Nursing and shown the pills as well as the MARS on which the RN had documented that the residents had received the pills. The RN was unable to explain how thirteen residents had not received medications and treatments as ordered for a specified date as well Resident # 14 did not receive a prescribed treatment.
The RN when questioned by the Director of Nursing about Resident # 9 missing narcotic was unable to explain how this could be administered for a specified time when the resident had not received other prescribed medications for this specific date and specific time. The Director of Nursing also found a narcotic prescribed for resident # 12 discarded within the medication cart envelope.
Administrative staff at the home completed their internal investigation and as per the disciplinary action policy, terminated the RN and completed a report to the College of Nurses of Ontario.
The licensee has failed to comply with ON/Regulation 79/10 section 131.(2) by not ensuring that drugs are administered to residents in accordance with the directions for use as specified by the prescriber.

Issued on this 15th day of November, 2012

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