

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 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

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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 9, Dec 20, 2011; Jan 11, 2012	2011_105130_0025	Critical Incident
Licensee/Titulaire de permis		
1365853 ONTARIO LIMITED 3700 BILLINGS COURT, BURLINGTON Long-Term Care Home/Foyer de soin	minana minana mana	
MAPLE PARK LODGE 6 Hagey Avenue, Fort Erie, ON, L2A-5M	15	
Name of Inspector(s)/Nom de l'inspec	teur ou des inspecteurs	
GILLIAN HUNTER (130)		
Ins	pection Summary/Résumé de l'inspe	ection

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, Director of Care and staff related to H--00942-11.

During the course of the inspection, the inspector(s) Interviewed staff and reviewed clinical records.

The following Inspection Protocols were used during this inspection: Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON	I-RESPECT DES EXIGENCES
VPC - Voluntary Plan of Correction DR - Director Referral CO - Compliance Order	Legendé WN - Avis écrit VPC - Plan de redressement volontaire DR - Aiguillage au directeur CO - Ordre de conformité WAO - Ordres : travaux et activités



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Non-compliance with requirements under the Long-Term Care 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 fovers de Homes Act, 2007 (LTCHA) was found. (A requirement under the soins de longue durée (LFSLD) a été constaté. (Une exigence de la LTCHA includes the requirements contained in the items listed in 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. (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:

The licensee did not ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. In 2011 an identified registered practical nurse administered medication to an identified resident, for which the physician did not prescribe. The resident suffered ill effects as a result and was transferred to the hospital for assessment and treatment. The identified nurse who administered the medication admits that the resident was given medication prescribed for a co-resident, but is unable to confirm whose medication the resident received. The Registered Nurse, Director of Care and Administrator confirmed the medication error occurred.

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 11th day of January, 2012

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

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