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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 26, 2016	2016_356618_0009	013085-16	Critical Incident System

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

CECILIA FULTON (618)

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 9,10,11,12,13,16,17,18,19, 2016.

This Critical incident inspection was related to a medication error.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurse (RPN), Registered Nurse (RN), Pharmacist, Director of Care (DOC) and Administrator.
During the course of this inspection, the inspector reviewed resident health records, medication incident report and documentation of home's investigation.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

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 :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Record review revealed that Resident #001 was administered a medication that had not been prescribed for them.

Record review revealed that a Physician's Digiorder form which had not clearly identified the Resident had been received electronically in the pharmacy. The pharmacy processed the order and it was put on Resident #001's Electronic Medication Administration Record (E-MAR).

Registered staff #101 administered the medication as it appeared on the E-MAR to resident #001. Staff #101, when questioned by the Resident's family member about this medication went to clarify the order and was unable to locate the Digiorder form in Resident #001's chart, however the order did appear on Resident #001's E-MAR.

Staff #101 called the pharmacy and it was determined that the order had been processed to the wrong Resident's chart and thus administered to the wrong Resident. Resident #001 did not suffer any negative consequences as a result of this medication error.

Interview with the Director of Care (DOC) and the Administrator confirmed that this medication error had occurred. [s. 131. (1)]

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.