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 prévue 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 soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 5, 2019	2019_569508_0010	002625-19	Complaint

Licensee/Titulaire de permis

St. Peter's Care Centres
125 Redfern Avenue HAMILTON ON L9C 7W9

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

St. Peter's Residence at Chedoke
125 Redfern Avenue HAMILTON ON L9C 7W9

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

ROSEANNE WESTERN (508)

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): February 20 and 21, 2019.

During the course of this inspection the inspector toured the facility, reviewed resident clinical records, the home's investigative notes and medication incident reports.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff and residents.

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	Légende 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident:
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.

A review of the clinical records for resident #001 and review of Critical Incident (CI) report #2927-000003-19, indicated that on an identified date in 2019, resident #001 alleged that they were given a medication that was not theirs.

The resident exhibited a change in condition and was transferred to the emergency room (ER) for further investigation as a medication error was suspected.

During the home's investigation it was questioned as to whether the resident received another resident's medication. The resident was transferred back to the home from the ER and it was undetermined if the resident received another resident's medication.

Co-resident #002, indicated during interview that they overheard resident #001 telling someone that they don't get medication at this time.
This information was confirmed with resident #001 during an interview conducted by the Long Term Care Homes Inspector on an identified date.

During interview with the Administrator and the Director of Care (DOC), it was discussed that a medication error where the resident had exhibited a change in their condition had not been confirmed; however, they could not confirm that this did not occur. The incident occurred on an identified date in 2019, and a report to the Director was not submitted until 18 days later.

It was confirmed during review of the resident's clinical records, the home's investigative notes and the CI report that the Director was not informed of the incident until 18 days later. [s. 107. (3) 5.]

Issued on this 26th day of March, 2019

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

Original report signed by the inspector.