



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
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Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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 |
|--|---------------------------------------|------------------------|--|
| Mar 26, 2014 | 2014_102116_0013 | T-746-13 | Critical Incident System |

Licensee/Titulaire de permis

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

SOUTHLAKE RESIDENTIAL CARE VILLAGE
640 GRACE STREET, NEWMARKET, ON, L3Y-2L1

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

SARAN DANIEL-DODD (116)

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): March 20, 21, 24, 2014

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

During the course of the inspection, the inspector(s) reviewed the health records of Residents #1 and #2, homes medication pass policy, medication incident report and education records for medication administration.

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

| | |
|---|--|
| <p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p> | <p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p> |
| <p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs



Specifically failed to comply with the following:

- s. 129. (1) Every licensee of a long-term care home shall ensure that,**
- (a) drugs are stored in an area or a medication cart,**
 - (i) that is used exclusively for drugs and drug-related supplies,**
 - (ii) that is secure and locked,**
 - (iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and**
 - (iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).**
 - (b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**
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Findings/Faits saillants :

1. The licensee failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

On a specified date, a medication cart on an identified unit was observed to be unlocked and unattended. The Registered staff member responsible for the unit confirmed that the medication cart should be locked at all times when unattended. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart, that is secure and locked, to be implemented voluntarily.

**WN #2: 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 failed to ensure that no drug is administered to Resident #1 unless the drug has been prescribed for the resident.

As confirmed through interviews with the registered staff and the Assistant Director of Care, on a specified date, a registered staff member administered resident #2's medications to resident #1. Resident #1 was transferred to the hospital for further observation and returned to the home the same day with no ill effect.

The registered staff member was terminated as a result of the medication incident. [s. 131. (1)]

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 administered to Resident #1 unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 2nd day of April, 2014

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

A handwritten signature in black ink, appearing to read "U. Paré" or similar, written over a white background within a rectangular box.