



**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
Performance Improvement and
Compliance Branch**

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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
Oct 21, 2013	2013_229213_0043	L-000741-13	Critical Incident System

Licensee/Titulaire de permis

S & R NURSING HOMES LTD.
265 NORTH FRONT STREET, SUITE 200, SARNIA, ON, N7T-7X1

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

AFTON PARK PLACE LONG TERM CARE COMMUNITY
1200 AFTON DRIVE, SARNIA, ON, N7S-6L6

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

RHONDA KUKOLY (213)

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): October 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, and two Registered Practical Nurses

During the course of the inspection, the inspector(s) made observations and reviewed health records and other relevant documentation

**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. 135. Medication incidents and adverse drug reactions



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Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1). (b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider as evidenced by:
 1. A Resident received a medication which had not been prescribed by the physician. The home did not notify this resident's Power of Attorney regarding this medication incident.
 2. A second Resident received a medication which had not been prescribed by the physician. The home did not notify this resident's Power of Attorney regarding this medication incident.
 3. A third Resident received a medication which had not been prescribed by the physician. The home did not notify this resident's Power of Attorney regarding this medication incident.
 4. The Director of Care confirmed that these medication incidents should have been communicated with the Powers of Attorneys of these residents and were not. [s. 135. (1)]
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Issued on this 21st day of October, 2013

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

Rhonda Kukoly