Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Sep 10, 2015	2015_324567_0003	T-2329-15	Critical Incident System

Licensee/Titulaire de permis

MON SHEONG FOUNDATION
36 D'Arcy Street TORONTO ON M5T 1J7

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

MON SHEONG HOME FOR THE AGED
36 D'ARCY STREET TORONTO ON M5T 1J7

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

SOFIA DASILVA (567)

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 5, 6, 7, 2015.

During the course of the inspection, the inspector(s) spoke with registered staff, the director of resident care (DORC)and the administrator.

The following Inspection Protocols were used during this inspection: Medication

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **1 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On April 9, 2015, at 8a.m., resident #1 was administered medication that was prescribed for administration on April 9, 2015, at 9p.m. and April 10, 2015, at 8a.m.

Record review and interview with the registered staff and director of resident care revealed that on April 9, 2015, at approximately 6:55a.m., the night shift registered staff checked on resident #1 and found that his/her blood pressure was elevated, with a reading of 212/62. The nurse proceeded to administer the resident's 8a.m. medication and documented in the medication administration record binder that the 8.a.m medications were administered by signing his/her initials. Review of the official signatures of registered staff revealed that the nurse's initials consisted of a single character resembling the same letter as the first letter of his/her name. When the day shift charge nurse arrived, the night shift nurse informed him/her verbally of the resident's elevated blood pressure and subsequent medication administration.

At approximately 8a.m. the day shift charge nurse informed the day shift registered staff of what happened and asked him/her to check on resident #1. The identified registered staff misunderstood the directions provided by the charge nurse. The identified registered staff checked resident #1's blood pressure and noted that it was within normal range. The identified registered staff then proceeded to administer the 8.a.m. medications: the identified registered staff checked the MAR and observed what appeared to be a signature documented in the MAR alongside the 8a.m. medication line. Record review of the medication documentation abbreviations in the footer of the MAR indicated that the signature character used by the nurse resembled the character that denotes that medications were held. The identified registered staff believed that the 8.a.m. medications were held and proceeded to open medication pouches for medication that was ordered for administration on April 9, 2015, at 9p.m and April 10, 2015, at 8 a.m.; the identified registered staff did not check pouch information for administration time and proceeded to administer these medications to the resident. The error was discovered immediately by the charge nurse together with the identified registered staff and was communicated to the DORC. Interventions were immediately implemented, including resident monitoring and communication with the resident's physician and family.

There was no adverse outcome to the resident.

The home submitted a Critical Incident System report to the ministry on April 10, 2015, regarding the medication incident.

Interview with the registered staff and the director of resident care confirmed that the medications were not administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

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 administered to residents in accordance with the directions for use specified by the prescriber, by the identified registered nursing staff, to be implemented voluntarily.

Issued on this 10th day of September, 2015

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

Original report signed by the inspector.