

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: September 20, 2023	
Inspection Number: 2023-1199-0003	
Inspection Type: Critical Incident	
Licensee: The Parkview Health Care Partnership on behalf of 593405 Ontario Limited as General Partner	
Long Term Care Home and City: Parkview Nursing Centre, Hamilton	
Lead Inspector Olive Nenzeko (C205)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 6-8, 11, 2023

The following intake(s) were inspected:

- Intake: #00001667 related to Medication Management.
- Intake: #00015521 related to Prevention of Abuse and Neglect.

The following **Inspection Protocols** were used during this inspection:

- Medication Management
- Infection Prevention and Control
- Prevention of Abuse and Neglect

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Administration of Drugs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

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

Rationale and Summary

A resident had a prescription for a specific drug to be given twice daily. Staff provided the resident a different drug, which belonged to another resident, instead of their prescribed medication.

A review of the resident's Medication Administration Record (MAR) did not include direction for the use of the drug that was administered to the resident.

The Director of Care (DOC) confirmed that the staff member administered the wrong medication to the resident.

Administering a medication that was not prescribed to the resident could result in unwanted side effects.

Sources: Medication incident report; MAR; Interview with DOC.

[C205]