Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
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Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: September 21, 2023	
Inspection Number: 2023-1208-0004	
Inspection Type: Complaint Critical Incident	
Licensee: Revera Long Term Care Inc.	
Long Term Care Home and City: Sara Vista, Elmvale	
Lead Inspector Gurvarinder Brar (000687)	**Inspector Digital Signature** Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.09.21 08:56:35 -04'00'
Additional Inspector(s) Kim Byberg (729)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 11-13 and 15, 2023

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00092804 related to medication management.

The following intake(s) were inspected in this complaint inspection:

- Intake: #00090617 related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

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

Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee has failed to comply with the home's medication management system including safe medication administration for resident #002 by staff.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that the medication management system included written policies and procedure for the accurate administration of medication and was complied with and updated in accordance with evidence-based practices.

Staff did not comply with the home's policy titled "Resident Identification Process" prior to administering medication to resident #002.

Summary and Rationale

Resident #002 received a medication in error. The resident was immediately assessed and further clinical actions were taken by the staff.

Registered Practical Nurse (RPN) #104 inadvertently administered incorrect medication to resident #002. RPN #104 stated that they were not familiar with the resident.

The home's Resident Identification Process Policy instructed staff to verify resident's identity using a first identifier of a digital photo and choose a second identifier from a list which could include a resident wristband, self identification, or a second staff member to verify the resident identity.

The Director of Care (DOC) acknowledged that RPN #104 should not have administered the medication unless they verified resident #002's identity with two sources.

Failure to utilize two methods of verifying resident #002 identity prior to administering the medication negatively impacted them and placed them at moderate of risk of harm to their health and well being.

Sources:

Review of clinical records, the home's policy titled "Resident Identification Process" revised March 31, 2023. Interview with RPN #104, Registered Nurse and DOC.

[729]