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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 17, 2023	
Inspection Number: 2023-1619-0003	
Inspection Type: Complaint Critical Incident	
Licensee: The Corporation of Norfolk County	
Long Term Care Home and City: Norview Lodge, Simcoe	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.10.18 09:27:01 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 11, 12, 13, 2023.

The following intake(s) were inspected:

- Intake: #00094205 CIS #M624-000016-23 related to medication management
- Intake: #00095651 CIS #M624-000018-23 related to infection prevention and control
- Intake: #00096322 and #00097602 a complaint related to allegations of retaliation.

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

Medication Management
Whistle-blowing Protection and Retaliation
Infection Prevention and Control

INSPECTION RESULTS

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 unless the drug had been prescribed for the resident.

Rationale and Summary
A critical incident system (CIS) report submitted to the Ministry of Long-Term Care, indicated that a resident was administered multiple medications which were not prescribed for them.

Review of a medication incident report and the resident's progress notes documented that the resident had been administered the medication in error and later required medical attention.

A Registered Nurse (RN) stated as soon as they realized they had administered the medication incorrectly, they took immediate action. Both the Manager of Nursing and Personal Care (MNPC) and the RN stated that the expectation was that staff make checks against the resident's electronic Medication Administration Record (eMAR) photo to ensure the right medications were administered to the right resident. In addition, staff could also check with other staff present on the unit, ask the resident their name or check the name on the resident's assistive device.

There was a risk to the resident for negative outcomes related to this medication error as the resident required medical attention.

Sources: a CIS report, the resident's clinical records, a Norview Lodge Medication Incident Report, and interviews with a RN and MNPC. [524]