RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: June 21, 2013	**Name of Inspector:** Ed Lum
Inspection Type: Mandatory Reporting Inspection	
Licensee: 1583187 Ontario Inc. / 2nd floor 307 King Street E., Hamilton, ON L8N 1C1 (the "Licensee")	
Retirement Home: Sheridan Lodge / 6 Sheridan Street, Brantford, ON N3T 2P6 (the "home")	
Licence Number: S0161	

Purpose of Inspection
The RHRA received a report under section 75(1) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances. Specifically, the Licensee failed to comply with the following subsections: **s. 30** If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that, (a) the drugs or other substances are stored in an area or a medication cart that, (i) is used exclusively for drugs or other substances and for supplies related to drugs or other substances, (b) controlled substances as defined in the *Controlled Drugs and Substances Act* (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. (c) an audit of the controlled substances mentioned in clause (b) is performed monthly.
Inspection Finding The Inspector found that two cabinets being used to store drugs or other substances are not being used exclusively for this purpose. Additionally, a resident's medications, including a controlled substance, were found stored in a single lock cabinet. The Inspector found that an audit of a resident's PRN medication of controlled substance, Oxycocet, was last completed on May 10, 2013 with 4 ½ tablets recorded as remaining. On the day of inspection, the remaining tablets could not be located and there was no documentation indicating their whereabouts.
Outcome Registrar Warning Letter issued.

2. The Licensee failed to comply with O. Reg. 166/11, s. 33; Medication error.

Specifically, the Licensee failed to comply with the following subsections:

s. 33 (2) If a medication error occurs in a retirement home or if a resident of the home has an adverse reaction to a drug or other substance administered to the resident in the home by the licensee or a member of the staff, the licensee shall ensure that,

(a) a written record is prepared documenting the error or reaction and the immediate actions taken to assess and maintain the resident's health;

(d) in the case of a medication error, corrective action is taken as necessary to prevent future harm to residents.

Inspection Finding

A medication error occurred on June 6, 2013 and the Administrator of the home was informed shortly after the incident. The Administrator confirmed that a written record of the error was not completed and no corrective action was taken by the home.

Outcome

The Licensee has taken corrective action.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Public Register, available online at http://rhra.ca/en/register/.

Signature of Inspector	Date
	October 23, 2013