

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: July 14, 2023	
Inspection Number: 2023-1380-0002	
Inspection Type: Critical Incident System	
Licensee: Deep River and District Hospital	
Long Term Care Home and City: The Four Seasons Lodge, Deep River	
Lead Inspector Emily Prior (732)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 10 and 11, 2023

The following intake(s) were inspected:

- Intake #00018238 (CI #2896-000002-23) Improper/Incompetent treatment of a resident related to a medication incident.

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 (3) (b) (i)

The licensee has failed to ensure that no person administers a drug to a resident in the home unless they are a member of a regulated health profession and are acting within their scope of practice.

On a specific date in January, 2023, a staff member told a Registered Practical Nurse (RPN) that they found a medicine cup with approximately five pills in it in a resident's room and that they gave these pills to the resident. The RPN immediately contacted the Director of Care (DOC) as they had watched the resident take both their morning and lunch medications that day, and was unsure what medications the resident may have taken.

In an interview with the DOC after the incident, the staff member indicated that they were not directed or supervised in the administration of the medications.

The DOC and RPN stated that only registered staff are to administer medications to residents. Furthermore, the DOC confirmed that the staff member was not a regulated health professional.

As a result of the staff member administering medications to the resident, there was risk of harm to the resident's health.

Sources: Resident's health care record; licensee investigation notes; CIR 2896-000002-23; and interview with RPN #104, DOC, and other staff.

[732]



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

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