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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: March 15, 2024
Inspection Number: 2024-1454-0001
Inspection Type: Critical Incident Follow up
Licensee: Spencer House Inc.
Long Term Care Home and City: Spencer House, Orillia

Lead Inspector	**Inspector Digital Signature**
Shannon Russell (692)	Shannon K Russell Digitally signed by Shannon K Russell Date: 2024.03.26 15:52:11 -04'00'

Additional Inspector(s)
Arash Pouralborz #000837 was present during this inspection.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 4-8, 2024.

The following intake(s) were inspected:

- Intake, related to Follow-up #: 1 - FLTCA, 2021 - s. 24 (1), duty to protect;
- Intake, related to a medication incident, resulting in the resident transferred to the hospital; and,
- Intake, related to an Acute Respiratory Illness outbreak.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1454-0004 related to FLTCA, 2021, s. 24 (1) inspected by Shannon Russell (692)

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee has failed to ensure that medication was administered to a resident as prescribed by the physician.

Rationale and Summary
A Registered Practical Nurse (RPN) administered the incorrect dosage of a specified medication to a resident, which resulted in them requiring additional medical treatment. The physician had ordered a specified medication with a specific dosage

to be administered at a scheduled time. The RPN reported to two Registered Nurses (RNs) that they had administered the incorrect dosage of the medication to the resident, as they stated that they had not viewed the physician's order prior to administering the medication.

Registered staff indicated that the long-term care homes (LTCHs) policy outlined that certain specified medications were to be flagged on the resident's electronic medication administration record (eMAR), and prior to administering the specified medications, registered staff were to complete independent double checks (IDCs). They all identified that the process consisted of two nurses working independently to verify the accuracy of the medication. The RNs identified that the RPN had not had another registered staff complete a double check prior to them administering the specified medication to the resident.

The Director of Care (DOC) verified that the RPN had not administered the correct dosage, as they did not follow the home's policy to complete the required checks prior to administering the medication to the resident.

There was moderate impact to the resident, as the incident resulted in the resident requiring additional medical intervention.

Sources: Critical Incident System (CIS) report; a resident's health care records; the home's internal investigation notes; medication incident report; the home's policies "The Medication pass", #5.6, last revised June 30, 2023, and "High Alert Medications", #VIII-E-10.90, last revised 11/2022; and interviews with the resident, RPNs, RNs, and the DOC. [692]