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: January 19, 2024
Inspection Number: 2024-1197-0001
Inspection Type: Complaint Critical Incident
Licensee: Jarlette Ltd.
Long Term Care Home and City: Temiskaming Lodge, Temiskaming Shores

Lead Inspector	**Inspector Digital Signature**
Charlotte Scott (000695)	Charlotte A Scott Digitally signed by Charlotte A Scott Date: 2024.01.25 08:09:09 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-11, 2024

The following intake(s) were inspected:

- One complaint intake related to care and medication administration;
- One intake related to an outbreak in the home.

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

Resident Care and Support Services
Medication Management
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)
Administration of drugs
s. 140 (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 246/22, s. 140 (1).

The licensee has failed to ensure that drugs administered to a specific resident were prescribed to the resident.

Rationale and Summary
Medications were administered to a resident in error by a registered staff member.

Review of the resident's medication records for the identified time period, indicated the resident was not prescribed one of the medications that was administered to them by the registered staff member. The Director of Care (DOC) confirmed that the resident was given the medications in error, and acknowledged that staff were not following the appropriate medication administration processes when the error occurred.

There was low impact to the resident when they were administered medication that was not prescribed to them.

Sources: Progress notes for the resident, the medication record for the resident, the

pharmacy incident form, and interviews with the DOC, and other staff.

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