Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 28, 2014	2014_271532_0009	L-000280-14	Complaint

Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7

Long-Term Care Home/Foyer de soins de longue durée

LANARK HEIGHTS LONG TERM CARE CENTRE
46 LANARK CRESCENT, KITCHENER, ON, N2N-2Z8

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 26, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care, Quality and Assistant Manager, Registered Practical Nurses, Personal Support Worker and residents

During the course of the inspection, the inspector(s) toured the resident home areas, review medical records, observed the provision of care and interaction between staff and residents, observed medication passes and medication storage areas.

The following Inspection Protocols were used during this inspection:
Medication

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration was approved by the prescriber in consultation with the resident.
Registered staff shared that the resident #002 administered their own topical cream along with other medications. Review of clinical records revealed that the resident #002 did not have an order for self –administration.
Registered staff confirmed that there was no physicians order for resident #002 to self-administer the topical cream. [s. 131. (5)]

Issued on this 28th day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Nusrat Ullin