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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2016	2016_384161_0028	020962-15 X 026346-15 X 027655-15 X 034128-15	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF LANARK
P.O. Box 37 Sunset Blvd. PERTH ON K7H 3E2

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

LANARK LODGE
115 Christie Lake Road, R. R. #4 Lot 27, Concession 2 PERTH ON K7H 3C6

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

KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 27, 28, 29, July 5, 6, 2016.

During the course of the inspection, the inspector(s) conducted nine critical incident inspections which included the following:
- four critical incidents related to responsive behaviors,
- one critical incident related to medications,
- four critical incidents related to falls.

During the course of the inspection, the inspector(s) spoke with identified Residents, Personal Support Workers, Registered Nursing staff, two Associate Directors of Care, the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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. (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. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee has failed to ensure that no drug is administered to a resident in the home unless the drug has been prescribed for the resident.

On a specific date in September 2015 the Director was notified via the Critical Incident Report System that earlier in the day, RPN #102 inadvertently administered resident #010's prescribed medications to resident #002. RPN #102 immediately realized her error and notified the Associate Director of Care (ADOC) #108. The ADOC #108 in turn, notified the attending physician of resident #002 who advised ADOC #108 to transfer resident #002 to hospital for assessment and monitoring. Resident #002 was subsequently transferred to the hospital and returned several hours later in stable condition.

On July 27, 2016 inspector #161 discussed the information contained in the Critical Incident Report with RPN #102. The RPN indicated to the inspector that on a specific date in September 2015 she had prepared resident #010's morning medications, placed them in a medication cup, and proceeded to the dining room to administer these medications to resident #010 whom she thought was eating lunch. When she entered into the dining room, she observed that resident #010 was not in the dining room and upon inquiry, was informed that the resident was asleep in his room. RPN #102 placed resident #010's medication cup back in her medication cart to be administered to resident #010 when he awoke. RPN #102 then started to prepare for the administration of medications for resident #002. The RPN was interrupted by a staff member who required her assistance. RPN #102 locked the medication cart and rendered assistance as requested. RPN #102 returned to her medication cart and observed that the medication administration record for resident #002 indicated that she had not yet administered resident #002's medications. RPN #102 opened the medication cart and in error, removed the medication cup belonging to resident #010. The RPN proceeded to administer the medications to resident #002, not to resident #010 as prescribed. RPN #102 immediately realized her mistake and contacted the ADOC #108.

On July 27, 2016 inspector #161 asked for and received from the home's Administrator the September 2015 Medication Administration Records for resident #002 and resident #010. A review of these medication administration records indicated that on a specific date in September 2015 resident #002 received the medications that were prescribed for resident #010. These medication records were reviewed by ADOC #108 as well as the home's Administrator who confirmed to inspector #161 that the medication administration error had occurred. Further discussion with the home's Administrator who indicated that RPN #102 received re-education regarding medication administration processes and that several strategies had subsequently been put in place to minimize the risk of a recurrence.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents as prescribed and that clear documentation processes are in place, to be implemented voluntarily.

Issued on this 7th day of July, 2016

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

Original report signed by the inspector.