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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: May 16, 2024
Inspection Number: 2024-1357-0002
Inspection Type: Complaint Critical Incident
Licensee: S & R Nursing Homes Ltd.
Long Term Care Home and City: Afton Park Place Long Term Care Community, Sarnia

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2024.05.22 08:27:07 -04'00'

Additional Inspector(s)
Tatiana McNeill (733564)
Iqbal Kalsi (743139)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 7, 8 and 9, 2024.

The following intake(s) were inspected:

- Intake: #00106379 CIS #2872-000002-24 related to Falls Prevention and Management
- Intake: #00108749 CIS #2872-000003-24 related to Infection Prevention and Control
- Intake: #00112013 CIS #2872-000004-24 related to Medication Administration
- Intake: #00113153 CIS #2872-000005-24 related to Prevention of Abuse
- Intake: #00114119 a complaint related to Maintenance Services.

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

Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (b)
Maintenance services
s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

The licensee has failed to ensure that the equipment, specifically the exhaust fan, in a resident's washroom was kept in good repair for an unknown period.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) from a complainant indicating that the exhaust fan was not working in a resident's washroom, and there were odors. During onsite observations it was noted that the air was stale and slightly odorous. Interview with the Environmental Services

Manager (ESM) confirmed the fan motor of the exhaust fan was burned out in a resident's washroom.

Risk was low to the resident.

Sources: Review of maintenance records, observations in the home and interview with ESM.
[743139]

WRITTEN NOTIFICATION: Administration of Drugs

NC #002 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 no drug was used by or administered to a resident unless the drug had been prescribed for the resident.

Rationale and Summary
Review of a critical incident system (CIS) report documented that a resident was administered multiple medications which were not prescribed for them. A medication incident form and progress notes documented that the resident had been administered the medication in error by a registered staff member, resulting in an increased risk to the resident for adverse effects.

The home's medication administration policy stated that residents would be correctly identified before receiving medications and treatments.

The Manager of Resident Care (MRC) said that the staff member had noted that they

were interrupted when giving out medications and gave the medications meant for another resident to the identified resident. The MRC said that the home's expected practice was that staff focus on one resident at a time and finish the process of administering that resident's medication prior to going to another resident. Staff could also ask the resident their name and use an identifier such as the resident's picture on the electronic Medication Administration Record (eMAR) to ensure the right medications were administered to the right resident.

There was a risk to the resident for adverse effects related to this medication error.

Sources: CIS report, a resident's clinical records, a Medication Incident Form, Medication Administration Policy #RCM 17-10 last revised date July 12, 2022, and interview with the MRC.
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