



**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  
Direction de l'amélioration de la  
performance et de la conformité**

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## **Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du apport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 22, 2015	2015_253614_0008	2748-000011-15	Critical Incident System

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### **Licensee/Titulaire de permis**

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED  
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE ARTHUR NURSING HOME  
215 ELIZA STREET P.O. BOX 700 ARTHUR ON N0G 1A0

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

CAROLYN MCLEOD (614)

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## **Inspection Summary/Résumé de l'inspection**



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

**This inspection was conducted on the following date(s): April 29, 30, May 1, 4, 5, 6, 7, 8 and 11, 2015.**

**This inspection was done in conjunction with RQI Inspection # L-002224-15**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Co-Director of Nursing, Registered Staff, Personal Support Workers, Ward Clerks, Clerical Clerks,**

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

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**Findings/Faits saillants :**



1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A physician's orders clearly indicated that a medication was to be held for an identified resident based on an assessment of that resident.

On a specific day, registered staff administered the medication prior to an assessment; once assessed it was found that the medication should not have been administered to the identified resident. This medication was not administered in accordance with the doctor's orders and as such placed the resident at risk of harm.

On that same day, that same resident received two doses of a pain medication that was to be administered prior to a specific procedure only. Neither time that this medication was administered, was the procedure occurring or planned to occur.

This medication was not administered in accordance with the doctor's orders and did cause the resident unnecessary discomfort related to the side effects of the administration of the medication. [s. 131. (2)]

***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 medications are administered to residents according to the directions as specified by the prescriber, to be implemented voluntarily.***

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**Issued on this 24th day of September, 2015**

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

**Original report signed by the inspector.**