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
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Original Public Report

Report Issue Date: September 19, 2023	
Inspection Number: 2023-1226-0005	
Inspection Type: Critical Incident	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care on Bonnie Place, St Thomas	
Lead Inspector Ina Reynolds (524)	**Inspector Digital Signature** Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.09.21 10:04:03 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 12, 13 and 14, 2023.

The following intake(s) were inspected:

- Intake: #00092654 CIS #2730-000031-23 related to the medication management system.

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

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 (2)

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

Rationale and Summary:
Review of a critical incident (CI) report, the electronic Medication Administration Record (eMAR) and progress notes documented that a resident had missed multiple doses of a specific drug, over several days as the supply of the medication had run out.

Review of a medication incident report noted the dose omissions and identified a lack of communication as a root cause.

The Director of Care (DOC) acknowledged the medication for the resident on the identified days were not administered as ordered by the physician.

There was a risk to the resident for negative outcomes when there was not a continuous supply of the medication to be administered in accordance with the directions for use specified by the prescriber.

Sources: A Critical Incident System (CIS) report, a Medication Incident report, a resident's clinical record, and interview with the DOC and other staff.

WRITTEN NOTIFICATION: Drug Record (Ordering and Receiving)

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 145 1.

The licensee has failed to ensure that a drug record recorded the date the drug was ordered, in respect of a resident's drug that was ordered in the home.

Rational and Summary:
Review of a critical incident report, the electronic Medication Administration Record (eMAR) and progress notes documented that a resident had missed multiple scheduled doses of a drug, as the supply of the medication had run out.

The home's CareRX "Reordering Medications" policy stated in part "Reorder medications when there is approximately 5 days supply remaining. Affix the reorder label of the desired medication to the next available space on the current Drug Record of Ordering / Reorder form. If the reorder label is not available, write the medication request on the form indicating resident's full name, medication name, strength and directions. Sign and date the request and Fax to Pharmacy and verify transmission of fax."

There was no Drug Record of Ordering / Reorder form or copy of the fax with the date the medication

was ordered for the resident.

The Director of Care (DOC) said that the medication was ordered, as per nurses' notes. Staff would have faxed the order to pharmacy, however, there was no record of the fax with the date the medication was ordered from pharmacy.

Sources: A Critical Incident System (CIS) report, the home's CareRX "Reordering Medications" Policy No: 4.4 with reviewed date June 30, 2023, a resident's clinical record, and interview with the DOC and other staff.