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: February 26, 2024
Inspection Number: 2024-1136-0001
Inspection Type: Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care on Mary Bucke, St Thomas

Lead Inspector	**Inspector Digital Signature**
Pauline Waldon (741071)	Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2024.03.05 11:09:37 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: February 7 - 9, 12, 13, 2024

The following intakes were inspected:

- Intake: #00099951 - CIS: 2627-000025-23 - Related to medication management
- Intake: #00100349 - CIS: 2627-000026-23 - Related to the prevention of abuse and neglect

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

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect

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)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that medication was administered to a resident as prescribed.

Rationale and Summary:

The resident was prescribed a dose of medication to be administered in addition to their regular dose of that medication, if the resident met specific criteria.

Over a twelve-day period, there were six occasions where the resident met the criteria and an additional dose of the medication was not administered as prescribed.

As a result of not administering the medication as prescribed, there was risk that the resident's medical condition was not managed as required.

Sources: Resident's Orders, Medication Administration Record (MAR), Progress Notes and interviews with the Nurse Practitioner and Director of Care (DOC).

[741071]

WRITTEN NOTIFICATION: Residents' Drug Regimes

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 146 (a)

Residents' drug regimes

s. 146. Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

The licensee failed to ensure that monitoring and documentation was completed for the effectiveness of a resident's medication.

Rationale and Summary:

The resident was prescribed a dose of medication to be administered in addition to their regular dose of that medication, if the resident met specific criteria.

The DOC reported that upon administering the additional dose of medication, nursing staff were required to follow-up to assess the effectiveness of the dose, which included a test and a progress note.

There were no follow-up test results or progress notes documented after additional doses of the medication were administered to the resident on four occasions over a twelve-day period.

In addition, a test result was not documented after a follow-up assessment of the resident on one occasion over the same twelve-day period.

Due to monitoring and documentation not being completed, there was risk that if additional action was required to manage the resident's medical condition, it would not have been identified.

Sources: Resident's MAR, Progress Notes, test results and interview with the DOC.

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