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: June 26, 2023
Inspection Number: 2023-1588-0005
Inspection Type: Complaint Critical Incident System
Licensee: Corporation of the County of Elgin
Long Term Care Home and City: Terrace Lodge, Aylmer

Lead Inspector	**Inspector Digital Signature**
Ali Nasser (523)	Ali Nasser Digitally signed by Ali Nasser Date: 2023.06.27 10:52:49 -04'00'

Additional Inspector(s)
Samantha Perry (740)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 22, 2023

The following intake(s) were inspected:

- Intake: #00088999 - related to a resident's fall.
- Intake: #00089183 - related to allegations of staff to resident neglect.
- Intake: #00089547 - related to resident care concerns.
- Intake: #00090255 - related to a medication incident.

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

Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Drug Administration

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.

Rational and Summary:
The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care. The CIS indicated the resident did not receive a medication as ordered.

A clinical record review for the resident showed the resident received a medication not as ordered by the physician.

In an interview the Administrator said the resident's medication was not administered to the resident as specified by the prescriber.

The resident was not administered a medication as ordered which put them at risk.

Sources: record reviews, staff interviews [523]