

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District

609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: March 5, 2024	
Inspection Number: 2024-1436-0001	
Inspection Type: Complaint Critical Incident	
Licensee: 1245556 Ontario Inc.	
Long Term Care Home and City: Burton Manor, Brampton	
Lead Inspector Gurvarinder Brar (000687)	Inspector Digital Signature
Additional Inspector(s) Janet Groux (606)	

INSPECTION SUMMARY

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

- Skin and Wound Prevention and Management
- Resident Care and Support Services
- Medication Management
- Infection Prevention and Control
- Falls Prevention and Management

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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).

Non-Compliance with O. Reg, 2021, s. 140 (2) related to Administration of drugs

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

Rational and Summary

A resident had an infection. The physician prescribed one tablet of antibiotics to be given once followed by administering the antibiotics twice daily for one week.

Resident received one tablet daily for one week.

The Director of Care (DOC) stated antibiotics were not administered as prescribed by the physician.

Impact and Risk

Failure to receive the treatment as prescribed may prolong the wound infection.

Sources

Resident's clinical records including progress note, electronic medication

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administration record and prescriber order form and Interview with DOC.

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