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

Ottawa Service Area Office
347 Preston Street, Suite 420
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559
ottawasao.moh@ontario.ca

Original Public Report

Report Issue Date: October 28, 2022

Inspection Number: 2022-1460-0001

Inspection Type:
Complaint
Critical Incident System

Licensee: AON Inc.

Long Term Care Home and City: Moira Place Long-Term Care Home, Tweed

Lead Inspector	**Inspector Digital Signature**
Amber Lam (541)	Amber Lam Digitally signed by Amber Lam Date: 2022.10.28 13:05:53 -04'00'

Additional Inspector(s)
Anna Earle (740789)
Polly Gray-Pattemore (740790)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
September 28-30 and October 4-5, 2022

The following intake(s) were inspected:
- Complaint related to short staffing and continence care.
- Critical Incident #2977-000002-22 - Fall with injury.
- Complaint related to care concerns including medication administration, food and nutrition, infection prevention and control and continence care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
N/A	N/A	N/A	#N/A	N/A

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The following previously issued Compliance Order(s) were found **NOT** to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
N/A	N/A	N/A	#N/A	N/A

The following previously issued Compliance Order(s) were closed.

Legislative Reference		Inspection #	Order #	Inspector (ID) who inspected the order
N/A	N/A	N/A	#N/A	N/A

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

Resident Care and Support Services
Continence Care
Medication Management
Continence Care
Infection Prevention and Control
Infection Prevention and Control
Food, Nutrition and Hydration
Infection Prevention and Control
Housekeeping, Laundry and Maintenance Services
Prevention of Abuse and Neglect
Safe and Secure Home
Falls Prevention and Management
Skin and Wound Prevention and Management

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)

Non-compliance with: O. Reg. 246/22 s. 140 (2) The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Rationale and Summary
A resident's health care record was reviewed and it was noted there was a physician's order indicating the resident was to receive specific medications on specific days. One day the resident was not administered one medication as ordered. The following day the resident was to receive a different medication and it was not administered as ordered. The next day the resident was to receive a third medication and it was not given as ordered.

The following month the resident was not administered a medication as ordered. The next day the resident was to receive a different medication and it was not administered as ordered. Three days later the resident was administered a medication that was not ordered to be administered that day.

The Director of Care (DOC) acknowledged the medication errors as described above.

When a resident does not receive a medication as ordered, it presents a risk to the resident's health.

Sources: Interviews with the DOC, an RPN and the resident, the record reviews for a resident including, electronic Medication Administration Records (eMARs) and task sheets.

[740789]