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: October 15, 2024
Inspection Number: 2024-1702-0004
Inspection Type: Complaint Critical Incident
Licensee: CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Southbridge London, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 8, 9, 10, 11, 2024

The following intake(s) were inspected:

- Intake: #00125496, Critical incident related to a resident's fall.
- Intake: #00127856, Critical incident related to allegations of staff to resident neglect.
- Intake: #00128428, complaint related to safety of a resident.
- Intakes: #00128802 and #00125866, Critical incidents related to falls were completed during this inspection.

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

Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The licensee has failed to ensure the home's Medication policies were complied with and implemented by staff as part of the home's Medication Management System for a resident.

Rational and Summary
A clinical record review for a resident showed a medical directive with specific medications to be administered as needed. The medical directive did not have the specific indicators as specified in the home's policy and procedure. A review of the Electronic Medication Administration Record (EMAR) showed the orders from the medical directive were not transcribed to the EMAR.

In an interview an Assistant Director of Care said the resident's medical directive did not have the identifiers as specified in the procedure and the orders were not transcribed to the EMAR. They said the home would be reviewing the medical directives and process related to transcribing orders.

During the inspection the ADOC said the home had revised the Medical Directive to comply with the home's policy.

There was a risk to the resident by not implementing the home's medication policies.

Sources: resident's medical directive and EMAR and ADOC interviews.