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

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

Original Public Report

Report Issue Date: January 8, 2024
Inspection Number: 2023-1315-0008
Inspection Type: Complaint Critical Incident
Licensee: 2063414 Ontario Limited as General Partner of 2063414 Investment LP
Long Term Care Home and City: Barnswallow Place Community, Elmira

Lead Inspector	**Inspector Digital Signature**
Brittany Nielsen (705769)	Brittany Nielsen Digitally signed by Brittany Nielsen Date: 2024.01.09 09:13:33 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 18-22, 2023 and January 2-4, 2024

The following intake(s) were inspected:

- Intake: #00097811 - related to use of glucagon for a resident
- Intake: #00100981 – Complaint regarding care /assessment of a resident

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control

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 (2)

Medication management system

s. 123 (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The licensee failed to ensure that staff followed the home's Medication Pass policy while administering medication to residents.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Medication Pass policy stated that at all times during a medication pass, no medications are to be left sitting on top of the cart while the cart is unattended.

Rationale and Summary

During a medication pass, Inspector #705769 observed staff leave resident medications on top of the medication cart while it was unattended.

By failing to follow the home's Medication Pass policy, there was risk of a medication error.

Sources: interviews with staff, observation, and record review of the home's Medication Pass policy.
[705769]