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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
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Original Public Report

Report Issue Date July 5, 2022
Inspection Number 2022_1031_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other ______________________

Licensee
Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation

Long-Term Care Home and City
Tilbury Manor Nursing Home, Tilbury

Lead Inspector
Cassandra Taylor (725)

Inspector Digital Signature

Additional Inspector(s)
Rhonda Kukoly (213)

Also present during the inspection was inspector;
Marian Keith (741757)

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 27-29, 2022.

The following intake(s) were inspected:

- Intake # 006568-22 (CIS # 1064-000006-22) related to resident-to-resident responsive behaviours
- Intake # 007774-22 (CIS # 1064-000007-22) related to falls prevention and management

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Safe and Secure Home

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INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

NC#001 remedied pursuant to FLTCA, 2021, s. 154(2)

O. Reg. 246/22 138(1)(a)(ii)

During an observation of a unit on a specific date, the inspector observed the medication cart outside of a residents' room unlocked and the nurse was not in sight. The registered staff was interviewed and indicated they would normally always lock their medication cart and locked it. No residents or visitors were noted in the vicinity of the medication cart.

During an observation on the unit on a specific date, inspector observed the medication cart outside of a residents' room unlocked and the nurse was not in sight. The registered staff was interviewed and indicated they would always lock their medication cart and did not realize they didn't lock the cart when they went to attend to a resident. The registered staff locked the medication cart. No residents or visitors were noted in the vicinity of the medication cart.

Inspector identified the area of concern with the Director of Care (DOC) on June 27, 2022. On June 29, 2022, Assistant Director of Care (ADOC) confirmed that education was completed with registered staff on June 27, 2022, about locking the medication carts and a reminder sent to all registered staff.

The inspector completed multiple medication cart observations during the inspection and did not observe any further unlocked medication carts.

Sources: Observation of first and second floor medication carts and staff interviews with registered staff and the ADOC.

Date Remedy Implemented: June 27, 2022 [725]