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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 20, 2024
Inspection Number: 2024-1031-0002
Inspection Type: Critical Incident Follow up
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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16-18, 2024

The following intake(s) were inspected:

- Intake: #00120604 / Critical Incident (CI) 1064-000017-24 - related to infection prevention and control
- Intake: #00123550 - Follow-up #: 1 - O. Reg. 246/22 - s. 77 (2) (b)
- Intake: #00123551 -Follow-up #: 1 - O. Reg. 246/22 - s. 79 (1) 6.
- Intake: #00123552 - Follow-up #: 1 - O. Reg. 246/22 - s. 148 (2) 2.
- Intake: #00123585 / CI 1064-000020-24 - related to medication management
- Intake: #00124757 / CI 1064-000023-24 - related to falls prevention and management

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2024-1031-0001 related to O. Reg. 246/22, s. 77 (2) (b)
Order #002 from Inspection #2024-1031-0001 related to O. Reg. 246/22, s. 79 (1) 6.
Order #004 from Inspection #2024-1031-0001 related to O. Reg. 246/22, s. 148 (2) 2.

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Falls 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)
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).

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

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Rationale and Summary
A resident was prescribed two medications. The medication administration record (MAR) noted that the medications were not administered for a specified period. The progress notes stated one medication was not available on the specified dates.

During an interview with a Registered Practical Nurse (RPN), they confirmed the one of the medications was not administered for the specified dates as the pharmacy had not delivered it. During an interview with the Registered Nurse (RN), they confirmed another medication was not administered as ordered.

There was moderate risk and low impact to the resident when the ordered medications were not administered to the resident.

Sources
Resident progress notes, resident's medication administration record, interview with RPN and interview with RN