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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 25, 2020	2020_797740_0029	020836-20, 022871-20	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

Long-Term Care Home/Foyer de soins de longue durée

Lambton Meadowview Villa
3958 Petrolia Line, R.R. #4 PETROLIA ON N0N 1R0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SAMANTHA PERRY (740)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 19 and 23, 2020.

The following intakes were completed within the Critical Incident Systems inspection:
Log# 020836-20 / CI# M547-000022-20 related to falls prevention and management; and
Log# 022871-20 / CI# M547-000024-20 related to a medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector(s) also made observations and reviewed residents' clinical records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to residents #002 unless the drug was prescribed for the resident.

A Critical Incident System (CIS) report was received by the Ministry of Long-Term Care (MLTC) regarding a medication incident involving resident #002.

Clinical records documented, that resident #002 consumed another resident's medications in error.

Interviews with a Registered Practical Nurse (RPN) and the Director of Nursing (DON) said, resident #002 consumed another resident’s medications in error. The risk to resident #002 increased when they consumed non-prescribed medications in error.

Sources: Interviews with the Director of Nursing and other staff, resident #002’s plan of care and the home’s medication incident investigation notes. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

A CIS report was received by the MLTC regarding a medication incident involving resident #002.

During the course of this inspection through record reviews and interviews with staff, resident #001 was found not to have received their prescribed medications.

Interviews with an RPN and the DON said, resident #001 did not receive their prescribed medications and should have. The risk to resident #001 increased when they did not receive their medications as prescribed.

Sources: Interviews with the DON and other staff, resident #001’s plan of care and the home’s medication incident investigation notes. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with O. Reg. 79/10, s. 131(1) administering only prescribed medications to residents and s. 131(2) residents must receive their medications as prescribed, to be implemented voluntarily.

Issued on this 25th day of November, 2020

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.