Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 6, 2018	2018_702197_0013	013800-18	Resident Quality Inspection

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

The Village Green Nursing Home
166 Pleasant Drive P.O. Box 94 Selby ON K0K 2Z0

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

JESSICA PATTISON (197), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): June 19-22, 25, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Clinical Care Coordinator, a Physician, the Maintenance Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, a member of the Family Council and other family members, the Residents' Council President and residents.

The inspectors also conducted a tour of the home, observed medication administration and resident care, reviewed resident health care records and the Residents' and Family Council Meeting minutes.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to resident #022 unless the drug had been prescribed for the resident.

Inspector #531 reviewed resident #022's physician orders which indicated that the resident's medication was reviewed on a specified date and the order for a particular medication had been discontinued. Two days later, RPN # 105 did not check the physician orders on the electronic medication administration record and administered the medication to resident #022, which was no longer prescribed for the resident. The physician and Substitute Decision Maker (SDM) were notified of the medication error. There were no ill effects to the resident as a result of the medication error.

During an interview with the Director of Care, they confirmed that on a specified date, RPN # 105 had administered a medication to resident #022 that was no longer prescribed for the resident. [s. 131. (1)]

Issued on this 6th day of July, 2018

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

Original report signed by the inspector.