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
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Original Public Report

Report Issue Date: January 30, 2023	
Inspection Number: 2023-1274-0006	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village of Winston Park, Kitchener	
Lead Inspector Robert Spizzirri (705751)	**Inspector Digital Signature** Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2023.01.30 14:37:31 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 18-19, 23-26, 2023

The following intake(s) were inspected:

- Intake: #00015305 related to medication management.
- Intake: #00016117 related to medication management.
- Intake: #00015684 related to skin and wound management.

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

Infection Prevention and Control
Skin and Wound Prevention and Management
Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints procedure — licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)

The licensee has failed to ensure that any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, is immediately forwarded to the Director.

O. Reg. 246/22 s. 109 (1) states that a complaint that a licensee is required to immediately forward to the Director under clause 26 (1) (c) of the Act is a complaint that alleges harm or risk of harm, including, but not limited to, physical harm, to one or more residents.

Rationale and Summary

The Director of Nursing Care (DNC) received a written complaint alleging the improper care of a resident, which may have resulted in harm.

The home forwarded the complaint to the Director 14 days later.

The AGM said that the complaint should have been reported immediately.

When the home failed to forward the complaint immediately, the Director was unable to take immediate actions, if required.

Sources: Critical Incident Report, Written Complaint, Complaints Procedure Policy (01/04/2023)

[705 751]

WRITTEN NOTIFICATION: Administration of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

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

Rationale and Summary

A Registered Nurse (RN) said that new orders were to be faxed to pharmacy immediately upon receiving them. They were to be signed twice by Registered team members to ensure orders were transcribed on the medication administration record (MAR) and received from pharmacy.

A prescriber ordered two pre-operative drugs to be administered to a resident for two days prior to surgery.

Orders were faxed to pharmacy 14 days later. One of the drugs was on backorder, and the other was dispensed to the home. Orders were not signed twice, and they were not transcribed on the MAR.

The resident did not receive the drugs pre-operatively as prescribed.

When the home failed to follow their process for new orders, the resident did not receive drugs as prescribed which increased the risk of harm post-operatively.

Sources: Resident MAR, pharmacy fax records, CareRX Policy 4.8 Documentation of Orders (March 2022), interview with RN and other staff.

[705 751]