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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_563670_0008	025093-18, 001396-19, 002628-19	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Aspen Lake
9855 McHugh Street WINDSOR ON N8P 0A6

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

DEBRA CHURCHER (670), CASSANDRA TAYLOR (725), MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 11, 12, 13, 14 and 15, 2019.

The following complaint reports were inspected during this inspection:
Log# 025093-18 IL-59909-LO related to positioning and plan of care.
Log# 002628-19 IL-63887-LO related to medication administration and care concerns.
Log# 001396-19 IL-63481-LO related to oral care concerns.

During the course of the inspection, the inspector(s) spoke with the General Manager, two Assistant Directors of Nursing Care, one Neighborhood Coordinator, four Registered Practical Nurses, and two Personal Support Workers.

During the course of the inspection Inspectors observed the overall cleanliness and maintenance of the building, observed medication storage and administration, observed staff to resident interactions and the provision of care, reviewed relevant clinical records and reviewed relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to an incident with resident #002 on a specific date. It was stated that on a specific date resident #002 was administered twice their prescribed dose of a specific medicaton.

A review of a medication incident report involving resident #002 stated that on a specific date, Registered Practical Nurse (RPN) administered a medication to resident #002 that was double to the prescribed dose.

A review of resident #002’s clinical record showed that resident #002 had an order for a specific medication to be administered two times daily with an option of two different but specific routes of administration. The electronic Medication Administration Record for resident #002 showed that on a specific date resident #002 was administered two doses of a specific medication via one of the prescribed specific routes.

During an interview with Inspector #721, the Assistant Director of Nursing Care (ADNC) #106 stated that at the time of the medication incident resident #002 had an order for a specific medication that could be administered be by either of the prescribed routes. ADNC #106 told Inspector #721 that on a specific date, the RPN administering resident #002’s medication gave resident #002 a specific dose of the prescribed medication which was twice the prescribed dose. They stated that resident #002 should have received one dose of the specific medication and not two doses.

The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber when resident #002 did not receive their medication as ordered. [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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 25th day of March, 2019

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

Original report signed by the inspector.