Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Sep 17, 2019	2019_563670_0033	015538-19, 016194-19, 016487-19	Critical Incident System

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 at St. Clair
1800 Talbot Road WINDSOR ON N9H 0E3

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

DEBRA CHURCHER (670)

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): Septermber 3, 4, 5 and 6, 2019

The purpose of this inspection was to inspect;
Log# 016487-19 CIS# 3046-000055-19 related to improper medication administration.
Log# 016194-19 CIS# 3046-000054-19 related to potential improper care.
Log# 015538-19 CIS# 3046-000053-19 related to falls with injury.

During the course of the inspection, the inspector(s) spoke with the Director of Nursing Care, one Assistant Director of Nursing Care, one Registered Nurse, two Registered Practical Nurses, one Neighborhood Coordinator, one Registered Practical Nurse Personal Expression Response Team Lead and two Personal Support Workers.

During the course of this inspection, the Inspector observed the overall cleanliness and maintenance of the facility, observed staff to resident interactions and the provision of care, observed medication administration and one drug storage area, reviewed relevant clinical records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

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 resident #003 unless the drug had been prescribed for the resident.

The home submitted a Critical Incident Report (CIS) to the Ministry of Long-Term Care related to a medication error involving resident #003.

Review of the CIS report and resident #003's clinical record showed that on a specific date a medication error occurred involving resident #003 resulting in specific medical interventions being required.

During an interview on September 4, 2019, Director of Nursing Care (DNC) #101 acknowledged that a medication error had occurred involving resident #003 that resulted in resident #003 requiring specific medical interventions.

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131.(1)]

2. The licensee has failed to ensure that drugs were administered to resident #006 and #007 in accordance with the directions for use specified by the prescriber.

A)Review of a medication incident report dated for a specific date, and resident #006's clinical record showed that resident #006 was to receive a medication at a specific time on a specific date and did not. The medication error was discovered during the afternoon narcotic count when it was noted that the medication had not actually been given.

During an interview on September 4, 2019, Director of Nursing Care (DNC) # 101

acknowledged that resident #006 did not receive their medication as prescribed on a specific date.

B)Review of a medication incident report dated for a specific date, and resident #007's clinical record showed that resident #007 was to receive a specific medication on a specific date at two specific times, and did not. The Registered Practical Nurse documented that the medication was unavailable. The medication error was discovered during the afternoon narcotic count when it was noted that the medication had not actually been given.

During an interview on September 4, 2019, Director of Nursing Care (DNC) # 101 acknowledged that resident #006 did not receive their medication as prescribed on a specific date.

The licensee has failed to ensure that drugs were administered to any resident in accordance with the directions for use specified by the prescriber. [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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 17th day of September, 2019

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

Original report signed by the inspector.