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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 8, 2019	2019_803748_0002	004230-19	Follow up

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 Tansley Woods
4100 Upper Middle Road BURLINGTON ON L7M 4W8

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

EMMY HARTMANN (748)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 29, May 3 and 7, 2019.

The following intake was completed in this inspection:
Log #004230-19 related to a follow up to CO #001 from inspection #2018_558123_0016/ 031839-18, 032045-18 regarding Ontario Regulation 79/10, s.131 (1), with a compliance due date (CDD) of March 15, 2019.

This inspection was completed concurrently with Critical Incident Inspection #2019_570528_0014, for which, Inspector Cynthia DiTomasso was present.

During the course of the inspection, the inspector(s) spoke with registered practical nurses (RPN), registered nurses (RN), and the Director of Nursing Care (DONC).

During the course of the inspection, the inspector(s) also observed the provision of care and services, and reviewed records, audits, and policies.

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 131. (1)	CO #001	2018_558123_0016	748

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that drugs were stored in a medication cart that was secured and locked.

In May, 2019, at an identified time, the medication cart in an identified home area, was observed to be unlocked while it was unattended in a resident area hallway. Registered Staff #103 was observed on the other side of the hallway, giving medication to a resident with their back turned from the medication cart. Registered Staff #103 indicated that they should have locked the medication cart while it was unattended.

In May, 2019, at an identified time, the medication cart in an identified home area, was observed to be unlocked while it was unattended outside of the dining room. Registered Staff #104 was observed to be inside the dining room. Registered Staff #104 indicated that they should have locked the medication cart while it was unattended.

In May, 2019, at an identified time, the medication cart in an identified home area, was observed to be unlocked while it was unattended outside of the dining room. Registered Staff #105 was observed to be inside the dining room. Registered Staff #105 indicated that they were in the dining room giving medication, and that they should have locked the medication cart while it was unattended.

During an interview with the Director of Nursing Care (DONC), they indicated that it was an expectation that medication carts be locked when they were unattended. The DONC also indicated that it was in the home's policy to ensure carts were locked when unattended.

The home's policy titled "Medication: Administration of Medications, Tab 05-03", provided to inspector by the DONC, stated "never leave an unlocked medication cart unattended".

The licensee failed to ensure that drugs were stored in a medication cart that was secured and locked.

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 stored in a medication cart are secure and locked, to be implemented voluntarily.

Issued on this 23rd day of May, 2019

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

Original report signed by the inspector.