Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Oct 21, 2020	2020_796754_0030	015352-20	Critical Incident System

Licensee/Titulaire de permis

Hanover Operating Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

The Village Seniors Community
101-10th Street HANOVER ON N4N 1M9

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

TAWNIE URBANSKI (754)

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): October 13, 14, 2020.

The following intake was completed during this critical intake inspection:
Log #015352-20, related to a missing narcotic.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse (RN), and Registered Practical Nurses (RPN's).

The inspector made observations of the home and resident/staff interactions. A record review of the plan of care of the identified residents was completed. The home's relevant policies and procedures and related documentation were also reviewed.

The following Inspection Protocols were used during this inspection:
Medication

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	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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the Medication Management policies and procedures included in the required Medication Management Program were complied with, for a resident.

In accordance with O. Reg. 79/10, s. 114 (1), and in reference to O. Reg. 79/10, s. 136. (1) the licensee was required to develop as part of the medication management system, a written policy developed in the home that provides for the ongoing identification, destruction and disposal of a resident’s drugs where the drug was discontinued. Specifically, staff did not comply with the home’s policy “Medication Handling-Specialty Drugs”, dated January 2019.

Five ampules of a narcotic medication removed from the locked drug destruction cabinet were found broken and did not contain any liquid during drug destruction.

It was determined that staff had dropped the box of narcotic medication contained in ampules on the floor, but did not followed procedures outlined in the home's policy related to drug wastage, because they did not check the box's contents after it was dropped.

Not following the home’s Policy “Medication Handling-Specialty Drugs” put the home at greater risk of drug diversion of a controlled substance.

Sources: The Critical Incident report, Medication Incident Report, Narcotic and Controlled Drug Record Form, Drug Count Sheet, eMAR documentation, Medication Handling-Specialty Drugs” policy (January 2019), interviews with Director of Care, Personal Support Workers and other staff. [s. 8. (1) (b)]

Issued on this 21st day of October, 2020

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

Original report signed by the inspector.