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 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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 30, 2018	2018_727695_0003	009581-18	Resident Quality Inspection

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 Winston Park
695 Block Line Road KITCHENER ON N2E 3K1

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

FARAH_ KHAN (695), MARIAN MACDONALD (137), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): May 15, 16, 17, 18, 22, 23, 24, and 25, 2018.

Inspector Valerie Goldrup (539) was also part of this inspection

Log# 006068-18 related to an unexpected death
Log # 032897-16 related to a fall that lead to death
Log #032153-16 related to a fall that lead to a wrist fracture
Log #023540-17 related to a fall with a laceration to the ear
Log #011186-16 related to a fall with a hip fracture

During the course of the inspection, the inspector(s) spoke with The General Manager (GM), Director of Nursing Care (DNC), Pharmacist, Kinesiologist, RAI Coordinator, Recreation Director, Environmental Director, Family Council President (FCP), Registered Nurses (RN), Registered Practical Nurses (RPN), student Registered Practical Nurse, Trussler Neighbourhood coordinator, Program Aide, Environmental services staff member, residents and family members.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care, reviewed relevant documents including but not limited to, clinical records, policies
and procedures, internal incident reports, and meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **2 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	Legendé 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 :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

During an afternoon narcotic count, Registered Practical Nurse (RPN) #116 was observed to enter a locked medication room and open the medication cart and narcotic bin without using a key. The following day when entering the medication room with RPN #125, Inspector #539 observed the medication cart and narcotic bin unlocked.

Registered Practical Nurse #125 acknowledged that the narcotic bin and the medication cart were open and should be kept locked. Director of Nursing Care (DNC) #100 stated that it was the expectation of the home that controlled substances were stored in a separate, double-locked area within the locked medication cart.

(539) [s. 129. (1) (b)]

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 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, to be implemented voluntarily.

WN #2: 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 provider.

A Medication Incident Report stated that resident #021 received a double dose of a controlled substance by student Registered Practical Nurse (RPN) #127 under the supervision of RPN #117. According to Resident #021's electronic Medication Administration Record (eMAR), resident #021 was scheduled to have one tablet of the medication four times a day. The incident report stated that student RPN #117 administered two tablets to resident #021 in the afternoon. No adverse effects to resident #021 were documented.

In an interview with RPN #117, Inspector #695 was informed that RPN #117 was with the resident at the time that student RPN #127 was obtaining the medication from the medication cart. Student RPN #127 was supposed to obtain the tablet that had already been dispensed and was stored in the narcotic bin of the medication cart. However, student RPN #127 dispensed another tablet into the cup containing the first tablet and administered both to the resident.

In an interview with Director of Nursing Care (DNC) #100, the DNC stated that a medication error occurred in which resident #021 received two tablets of a controlled substance instead of one.

The licensee failed to ensure that resident #021 was administered medication in accordance with the directions for use specified by the provider. [s. 131. (2)]

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber in regards to the review of a medication incident.

A physician's order stated that resident #022 was to receive a medication daily. A Medication Incident/Near Miss Report documented that resident #022 did not receive the specified medication at the specified time.

Registered Nurse (RN) #126 stated that the resident did not receive the dose of medication because it was not entered in the electronic Medication Administration Record (eMAR) by the Pharmacy. Pharmacist #129 stated that when the faxed order was received at the Pharmacy, the fax did not display the dose on that specific day. Director of Nursing Care #100 confirmed that the resident did not receive the medication as prescribed.

(539) [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 that are administered to residents are in accordance with the directions for use specified by the provider, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the advice of the Family Council was sought in developing and carrying out the satisfaction survey, and in acting on its results.

In an interview with the President of Family Council (FC), they stated that the FC had not been approached regarding their input into the development and carrying out of the satisfaction survey. The President of FC stated they had a lot of input that would have been shared if their advice was sought.

The FC meeting minutes were reviewed in the last year; there was no documentation in the meeting minutes that the FC was asked for input into the development and carrying out of the satisfaction survey. General Manager (GM) #101 was unable to provide meeting minutes for 2018 however stated that there may have been one that occurred and the Satisfaction Survey was not discussed.

General Manager #101 acknowledged that the FC was not given the opportunity to provide their feedback on the development and implementation of the satisfaction survey.

The licensee failed to ensure that the advice of the Family Council was sought in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

Issued on this 31st day of May, 2018

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

Original report signed by the inspector.