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
Nov 4, 2021	2021_747725_0036	013436-21, 014192-21, 014193-21, 015003-21	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 of Aspen Lake
9855 McHugh Street Windsor ON N8P 0A6

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

CASSANDRA TAYLOR (725)

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 27, 28, November 1,2,3, and 4, 2021.

This inspection conducted concurrently with inspection #2021_747725_0037

During the course of this inspection the following intakes were inspected;
Log # 014192-21 - Follow-up to Compliance Order # 001 from inspection #2021_678590_0015 / 004726-21, 006192-21, 008240-21, 009789-21 regarding s. 6. (7), CDD Sep 30, 2021
Log # 014193-21 - Follow-up to Compliance Order # 001 from inspection # 2021_678590_0016 / 006720-21, 007516-21, 007523-21, 008296-21 regarding r. 8. (1), CDD Sep 30, 2021
Log # 013436-21 / CIS # 3037-000029-21 - relating to medications
Log # 015003-21 / CIS # 3037-000033-21 - relating to injury of unknown origin

During the course of the inspection, the inspector(s) spoke with the General Manger, the Director of Nurse Care, two Assistant Directors of Nursing Care, one Previously Acting Assistant Director of Nursing Care/ Resident Assessment Instrument/ Minimum Data Set Coordinator, one Registered Nurse, one Practical Nurse, nine Personal Support Workers, one Housekeeping staff and residents.

During the course of this inspection the inspector(s) also conducted observations and record review relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Training and Orientation

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
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2021_678590_0015	725
O.Reg 79/10 s. 8. (1)	CO #001	2021_678590_0016	725

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident did not receive a drug unless it was prescribed for them.

A resident was given medications in error by a Registered Practical Nurse (RPN). The resident received; 5 medications not prescribed to them. As a result of the error the resident was later transferred to the hospital for additional interventions, after monitoring and interventions in the home were unsuccessful. The resident later returned to the home with no further interventions required. During an interview with the General Manager (GM) it was confirmed the incident had occurred and staff took corrective action immediately.

Administering medications that were not prescribed to the resident placed the resident at an increased risk for a medical event.

Sources: Critical Incident Report, medication incident report, the resident's medical records and staff interviews. [s. 131. (1)]

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 the resident and any other resident does not receive a drug that was not prescribed to them, to be implemented voluntarily.

Issued on this 9th day of November, 2021

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

Original report signed by the inspector.