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
Feb 3, 2020	2020_538144_0009	001067-20	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

CAROLEE MILLINER (144)

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): January 28, 2020.

The following intake was inspected within this inspection:
Log 001067-20, CIS 3046-000004-20 related to administration of drugs.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, the Environmental Services Manager and four Registered Practical Nurses.

During the course of the inspection, the inspector observed three Registered Practical Nurses during the 1200 hour medication pass, reviewed ten resident clinical records and the home policy related to management of medication incidents.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee did not ensure that medication incidents involving residents were documented, together with a record of the immediate actions taken to assess and maintain the residents' health.

CI 3046-000004-20 was reviewed by the inspector and included that on one identified date, a medication incident effecting several resident's occurred.

One Assistant Director of Care (ADOC) told the inspector that individual medication incident reports were not completed for the residents effected by the medication incident.

The ADOC shared that identification of the residents effected by the incident had been included in the critical incident report.

The home's medication incident management policy last reviewed on January 10, 2018, included that upon discovery of a medication incident, including near misses, the incident will be documented prior to the end of the shift on the client care portal medication incident reporting form (IR) or through the MediSystem medication incident reporting system (MIRS).

The ADOC acknowledged that medication incident reports should have been completed for the resident's effected by the medication incident.[s. 135. (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 ensure that medication incidents involving residents are documented, together with a record of the immediate actions taken to assess and maintain the residents' health, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the written records for identified residents were kept up to date at all times.

CI 3046-000004-20 was reviewed by the inspector and included that on one identified date, a medication incident effecting several resident's occurred.

Review of the resident clinical records revealed that on one identified date, the Power of Attorney's (POA) for the effected resident's were notified that an incident occurred however, the clinical record did not include information about the incident.

One Assistant Director of Care (DOC) shared with the inspector that the references in the resident progress notes related to the medication incident and that the POA's were directed to contact the home at a later date if they had questions.

The ADOC shared with the inspector that the critical incident report included the identification of each effected resident and the medication incident and, that incident reports had not been completed for the residents.

The ADOC further acknowledged that not including in resident progress notes, that a medication incident had occurred, did not ensure that residents written records were kept up to date. [231.(b)]

Issued on this 3rd day of February, 2020

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

Original report signed by the inspector.