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

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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
Dec 17, 2018	2018_702197_0024	016687-18	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

The Palace
92 Centre Street ALEXANDRIA ON K0C 1A0

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): On-site November 1, 5-9, 13, 14, Off-site November 26-30, Dec 3, 4, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, Registered Nurses and a resident.

The inspector also reviewed resident health care records, relevant policies and procedures, internal investigation files, a letter of complaint, emails, employee records and listened to multiple voice recordings.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Pain
Prevention of Abuse, Neglect and Retaliation

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. 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 are administered to residents in

accordance with the directions for use specified by the prescriber.

On a specified date, a particular medication was ordered for resident #002 to be given by mouth two times a day for pain.

Resident #002's Medication Administration Record (MAR) was reviewed for a 1 month time period and it was found that one of the doses of the medication was held 9 times and 8 were by RN #104.

The progress notes indicated each time the medication was held that the resident was not displaying signs of pain.

During a telephone interview with RN #104, they stated that they were noticing that resident #002 was refusing care and was getting upset at the one particular administration time. RN #104 indicated to the inspector that even though the documentation does not reflect this, the resident was typically asleep at this time. RN #104 went on to say that in their experience with resident #002, they did not feel the specified dose/administration time was required, however, they recognized that holding the medication was not the right way to go about having the order discontinued.

The Director of Care indicated to the inspector that they would expect a regularly scheduled medication order to be given as prescribed and if the RN did not feel the order was required, they would be expected to consult the Physician and interdisciplinary team.

The specified dose of medication for resident #002 was not given as specified by the prescriber, 9 times in a particular month. [s. 131. (2)]

2. On a specified date, a medication was ordered for resident #001 to be given once daily, as needed.

On two dates in a specified month, resident #001 was given the above medication twice on a shift by RN #103.

The progress notes support that RN #103 gave the medication twice on both shifts and documented that it was given with another medication to help treat the resident's pain.

During a telephone interview with RN #103, they denied having given the specified

medication more than what was prescribed for resident #001.

The ADOC was interviewed and indicated that this medication incident had come to light during an investigation that was conducted by the home.

The identified medication was not administered to resident #001 on two shifts, as specified by the prescriber. [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 are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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 has failed to ensure that each medication incident involving a resident is reported to the resident's substitute decision-maker.

During an investigation carried out by the home, they discovered a medication incident involving resident #001 that had occurred on two shifts in a particular month.

The medication incident form was reviewed and there was no indication that the resident's SDM had been notified.

The Director of Care informed the inspector that the home had not notified resident #001's SDM of the medication incident. [s. 135. (1) (b)]

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.