Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANA STENLUND (163)
Inspection No. / No de l'inspection :	2013_139163_0020
Log No. / Registre no:	S-000245-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 29, 2013
Licensee / Titulaire de permis :	F. J. DAVEY HOME 733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1
LTC Home / Foyer de SLD :	F. J. DAVEY HOME 733 Third Line East, Sault Ste Marie, ON, P6A-7C1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	PETER J. MACLEAN

To F. J. DAVEY HOME, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2012_099188_0027, CO #009;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
   i. a physician,
   ii. a registered nurse,
   iii. a registered practical nurse,
   iv. a member of the College of Occupational Therapists of Ontario,
   v. a member of the College of Physiotherapists of Ontario, or
   vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Order / Ordre :

The licensee shall ensure that when a PASD is used, for residents, #701, #801 and #151, under subsection (3) to assist them with a routine activity of daily living, it is included in their plan of care only if all requirements are satisfied. Specifically, the PASD must have been approved by a physician, registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations. The licensee shall also ensure that the PASD has been consented to by the resident, or if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Grounds / Motifs :

1. S.33(4)(3)(4) was previously issued as a CO #009 during inspection #2012-099188-0027 in July 2012.

Inspector reviewed the health care records including the plans of care for three residents (#701, #801 and #151) where documentation indicated the use of 1/2 rails (either one or two) for bed mobility. Staff interviewed by the inspector confirmed the use of these rails as PASDs. The inspector interviewed registered nursing staff who were unable to locate documentation for these residents indicating the PASDs had been approved by a physician, registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulation. Further, the inspector was unable to locate any documentation indicating that the use of the rails as a PASD, was consented to by the resident, or a substitute decision-maker of the resident with authority to give that consent. The licensee failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living is included in a resident's plan of care only if all of the following are satisfied: The use of the PASD has been approved by a physician, registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations and the use of the PASD has been consented to by the resident, or if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

(163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2012_104196_0033, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee shall ensure that for residents, specifically #151, #410, and #145 who require a restraint as outlined in their plan of care, that their condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances.

Grounds / Motifs :

1. Three previous Written Notifications (WNs) of non-compliance under O.Reg. 79/10, s.110(2)6 have been issued. Compliance Orders (CO) have been previously issued in: February 2012 during inspection #2012-099188-0005, in July 2012 during inspection #2012-099188-0027 and during inspection #2012-099188-0027 in Nov. 2012.

Inspector observed during the course of the inspection that resident #410 had a table top attached when in their wheelchair and noted that their care plan document indicated this piece of equipment was classified as a restraint. Inspector reviewed the restraint monitoring record and noted that there were 5 shifts where registered nursing staff did not initial that they had reassessed the resident at least every eight hours. Inspector interviewed a registered nursing staff who confirmed that registered nursing staff had failed to comply with this requirement. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That resident's #401 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. (163)

2. The inspector observed resident #145 during the course of the inspection to have a rear fastening table top when in their wheelchair. Inspector reviewed the restraint's plan of care which identifies the table top as a restraint. Inspector noted on the resident's restraint monitoring record that the section for registered nursing staff to initial identifying that they had reassessed the resident at least every eight hours was blank on 4 shifts during August 1-14, 2013. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6: That resident's #145 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. (163)

3. The inspector observed resident #151 during the course of the inspection to have a rear fastening lap tray when in their wheel chair and noted that this piece of equipment was documented as a restraint in the plan of care. Inspector

reviewed the restraint monitoring record for resident #151 and noted the section for the registered nursing staff to initial identifying that they had reassessed the resident at least every eight hours was blank on 5 shifts during August 1-14, 2013. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6: That resident's #151 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2012_104196_0033, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall ensure that for residents #101, #201 and #601 and any other resident that this may apply, that their drugs are administered in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. Two Written Notifications (WNs) and a Voluntary Plan of Action (VPC) were previously issued for O.Reg. 79/10,s.131(2) during inspection #2012-099188-0005 in February 2012 and a Compliance Order (CO) was previously issued in November 2012 during inspection #2012-104196-0033.

The inspector reviewed the Treatment Administration Record (TAR) book and interviewed registered nursing staff about documentation requirements when administering treatments. Staff reported to the inspector that registered nursing staff are to initial on the TAR indicating that the treatment was administered to the resident. Inspector noted that there were three resident's TAR records where registered nursing staff had not consistently initialled, indicating that they had administered the prescribed treatments.
Resident #201 had a physician's prescription for a treatment requiring it to be applied once daily. It was noted that between Aug 1 -14, 2013, two treatments were not recorded as having been administered as specified by the prescriber.
Resident #101 was prescribed a treatment requiring it to be applied twice daily. It was noted that between Aug 1-13, 2013, four treatments were not recorded as having been administered as specified by the prescriber.
Resident #601 was prescribed a treatment requiring it to be applied three times daily. Inspector noted that from Aug 1-14, 2013, seven treatments were not recorded as having been administered as specified by the prescriber. The licensee has not ensured that drugs are administered to residents in accordance with the directions for use specified by the prescriber. (163)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 29th day of August, 2013

Signature of Inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 29, 2013	2013_139163_0020	S-000245-13	Follow up

Licensee/Titulaire de permis

F. J. DAVEY HOME
733 Third Line East, Box 9600, Sault Ste Marie, ON, P6A-7C1

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

F. J. DAVEY HOME
733 Third Line East, Sault Ste Marie, ON, P6A-7C1

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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): Aug 14-16 and 19-20, 2013

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, registered nursing staff, personal support workers and residents.

During the course of the inspection, the inspector(s) walked through resident home areas, reviewed home policies on medication management, restraints and personal assistive service devices (PASD), observed resident care, staff to resident interactions, and reviewed health care records and documentation.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Minimizing of Restraining

Personal Support Services

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

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Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. Inspector reviewed the health care records including the plans of care for three residents (#701, #801 and #151) where documentation indicated the use of 1/2 rails (either one or two) for bed mobility. Staff interviewed by the inspector confirmed the use of these rails as PASDs. The inspector interviewed registered nursing staff who were unable to locate documentation for these residents indicating the PASDs had been approved by a physician, registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulation. Further, the inspector was unable to locate any documentation indicating that the use of the rails as a PASD, was consented to by the resident, or a substitute decision-maker of the resident with authority to give that consent. The licensee failed to ensure that the use of a PASD to assist a resident with a routine activity of daily living is included in a resident's plan of care only if all of the following are satisfied: The use of the PASD has been approved by a physician, registered nurse, a registered practical nurse, a member of the College of Occupational Therapists of Ontario, a member of the College of Physiotherapists of Ontario or any other person provided for in the regulations and the use of the PASD has been consented to by the resident, or if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The inspector observed resident #151 during the course of the inspection to have a rear fastening lap tray when in their wheel chair and noted that this piece of equipment was documented as a restraint in their plan of care. Inspector reviewed the restraint monitoring record for resident #151 and noted the section for the registered nursing staff to initial identifying that they had reassessed the resident at least every eight hours was blank on 5 shifts during August 1-14, 2013. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6: That resident's #151 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

2. The inspector observed resident #145 during the course of the inspection to have a rear fastening table top when in their wheelchair. Inspector reviewed the restraint's plan of care which identified the table top as a restraint. Inspector noted on the resident's restraint monitoring record that the section for registered nursing staff to initial identifying that they had reassessed the resident at least every eight hours was blank on 4 shifts during August 1-14, 2013. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6: That resident's #145 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

3. Inspector observed during the course of the inspection that resident #410 had a table top attached when in their wheelchair and noted that their care plan document indicated this piece of equipment was classified as a restraint. Inspector reviewed the restraint monitoring record and noted that there were 5 shifts where registered nursing staff did not initial that they had reassessed the resident at least every eight hours. Inspector interviewed a registered nursing staff who confirmed that registered nursing staff had failed to comply with this requirement. The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 6. That resident's #401 condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered

nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. [s. 110. (2) 6.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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 inspector reviewed the Treatment Administration Record (TAR) book and interviewed registered nursing staff about documentation requirements when administering treatments. Staff reported to the inspector that registered nursing staff are to initial on the TAR indicating that the treatment was administered to the resident. Inspector noted that there were three resident's TAR records where registered nursing staff had not consistently initialled, indicating that they had administered the prescribed treatments.
Resident #201 had a physician's prescription for a treatment requiring it to be applied once daily. It was noted that between Aug 1 -14, 2013, two treatments were not recorded as having been administered as specified by the prescriber.
Resident #101 was prescribed a treatment requiring it to be applied twice daily. It was noted that between Aug 1-13, 2013, four treatments were not recorded as having been administered as specified by the prescriber.
Resident #601 was prescribed a treatment requiring it to be applied three times daily. Inspector noted that from Aug 1-14, 2013, seven treatments were not recorded as having been administered as specified by the prescriber. The licensee has not ensured that drugs are administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

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. 3. (1)	CO #001	2013_139163_0004	163
O.Reg 79/10 s. 36.	CO #004	2012_099188_0027	163
O.Reg 79/10 s. 50. (2)	CO #002	2012_104196_0033	163
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2012_104196_0033	163
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2013_139163_0005	163

Issued on this 29th day of August, 2013

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

Linda Tower, Manager for Diana Stenlund