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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 17, 2016	2016_450138_0033	013481-16	Resident Quality Inspection

Licensee/Titulaire de permis

ARNPRIOR (THE) AND DISTRICT MEMORIAL HOSP.
350 John Street North ARNPRIOR ON K7S 2P6

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

THE GROVE, ARNPRIOR AND DISTRICT NURSING HOME
275 IDA STREET NORTH ARNPRIOR ON K7S 3M7

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

PAULA MACDONALD (138), RUZICA SUBOTIC-HOWELL (548)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 11, 12, 13, and 14, 2016.

Complaint Inspection 000248-16 and Critical Incident Inspection 002938-16, both relating to potential resident abuse, were completed as part of the RQI.

During the course of the inspection, the inspector(s) spoke with residents, family members, the Director of Care, the Activity Coordinator, the Maintenance Supervisor, the Infection Prevention and Control Coordinator, registered nurse (RNs), registered practical nurses (RPNs), personal support workers (PSWs), the President of the Family Council, and a member of the Residents' Council.

The inspectors also observed residential areas, reviewed resident health care records, observed a medication pass, reviewed internal investigation documents including partial employee file documents, reviewed Residents' Council meeting minutes, and reviewed the home's policies in relation to medication administration.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

The licensee failed to ensure that the no resident administers a drug to himself/herself unless the administration has been approved by the prescriber in consultation with the resident.

1. On October 11, 2016, it was observed by Inspector #548 that resident #045 was holding a topical gel medication in its original packaging with no prescription label while seated in the dining room during lunch service. At 1215 hours, during an interview, resident #045 indicated that the resident will apply the gel topically to the affected area, when needed. The resident could not indicate how many times the topical gel medication was self applied to the affected area.

On October 11, 2016, during an interview, RPN #047 indicated that resident #045's family supplies the topical gel medication and that the resident will self-administer the medication as the resident is thought to be capable to do so.

A review of resident #045's health care record showed a physician's order dated in July 2016, that supported the use of the topical gel medication and that this medication would be supplied by the family. There was no further documentation in the health care record to support the self administration of the topical gel medication by resident #045.

2. On October 12, 2016, Inspector #138 noted at approximately 0945 hours that resident #009 had a puffer that contained inhaled medication at the bedside table in the resident's room. The resident stated to the Inspector that the puffer is usually kept on the bedside table and that the puffer is self administered by the resident as needed.

A review of resident #009's health care record showed a physician's order dated in December 2014, that supported the use of the inhaled medication via puffer. This physician's order was a current order. There was no other documentation in the resident's health care record to support the self administration of this inhaled medication via puffer.

On October 12, 2016, during an interview with Inspector #548, resident #009 indicated that the puffer was self administered that morning at 0800 hours.

On October 12, 2016, during an interview, the unit RPN indicated that the resident is not to self-administer any medications. The RPN indicated that she would immediately rectify the situation.

On October 12, 2016, during an interview, the Director of Care indicated that there are no residents at the present time approved to self-administer medications.

The home's policy titled, "Resident Self-Administration, #03-04-10", dated October 1, 2012, specifies that a physician's order for resident self-administration of medications is required. [s. 131. (5)]

Issued on this 17th day of October, 2016

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

Original report signed by the inspector.