

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Type of Inspection / Registre no Genre d'inspection	
Mar 4, 2014	2014_211106_0005	S-000033-14 Complaint	

Licensee/Titulaire de permis

KENORA DISTRICT HOME FOR THE AGED BOARD OF MANAGEMENT 35 Van Horne Avenue, Box 725, DRYDEN, ON, P8N-2Z4

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

PRINCESS COURT

PRINCESS STREET, BOX 725, DRYDEN, ON, P8N-2Z4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs MARGOT BURNS-PROUTY (106)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): February 6, 7, 2014

The following log was reviewed as part of this inspection: Log# S-000033-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Family Members, and Residents

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records.

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

Findings of Non-Compliance were found during this inspection.



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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES		
Legend	Legendé	
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.	
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Ce qui suit constitue un avis écrit de non- respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.	



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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. On February 7, 2014, inspector reviewed progress note for resident #001. It was documented in this note that the registered staff member administered a medication to the resident twice on that particular day. The inspector reviewed the Medical Administration Record (MARs) and physician's orders for resident #001 and there were no orders prescribing this medication for this resident.

On February 7, 2014, inspector interviewed the registered staff member who created the above progress note, they told the inspector that they administered the medication twice to the resident on that particular day as indicated in the progress note. The registered staff member also showed the inspector a package of the medication and indicated that this was the same medication that they recalled administering to resident #001.

A progress note created by another registered staff member on the following day was reviewed by the inspector, it documented that a different dose of the same medication was also administered to the resident on the same day.

The licensee failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. [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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.



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Issued on this 4th day of March, 2014

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

