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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 5, 2014	2014_271532_0026	000426-14	Complaint

Licensee/Titulaire de permis

OAKWOOD RETIREMENT COMMUNITIES INC.
325 Max Becker Drive, Suite 201, KITCHENER, ON, N2E-4H5

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

THE VILLAGE OF RIVERSIDE GLEN
60 WOODLAWN ROAD EAST, GUELPH, ON, N1H-8M8

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

NUZHAT UDDIN (532)

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): August 1, 2014

Concurrent Complaint # 002695-14

During the course of the inspection, the inspector(s) spoke with the General Manager, Clinical Nurse, Assistant Director of Care, Neighbourhood Coordinator, Director of Programs, Director of Food Services and Chair of Health Safety Committee, Registered Practical Nurses(RPN), Student Practical Nurse(SPN), Personal Support Worker(PSW), Environmental Services staff and the Residents.

During the course of the inspection, the inspector(s) toured the resident home areas, review medical records, observed the provision of care and interaction between staff and residents.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, put in place was complied with. O. Reg. 79/10, s. 8 (1).

Policy on Administration of Medications directed registered staff to “never leave the medication for the resident to administer unless there was a physician’s order that allows the person to self-medicate” and “nor chart the medication as given unless they have personally given the medication.”

Inspector observed liquid medication and pills sitting in a medication cup on the resident's bedside table. Resident was observed in the bathroom at the time.

In an interview the Registered Practical Nurse (RPN) confirmed that she left the medication for the resident as resident was in the bathroom and shared that she was aware that the medication was not to be left in the room unless there was a physician’s order to self- administer.

RPN also shared that the liquid medication in the cup was not from today and believed that resident had been given the medication, however, resident reported that they had not taken the medication.

The Student Practical Nurse (SPN) confirmed that she had not given the medication to the resident and meant to go back as the resident had refused the first time, however, she forgot to go back to the resident to offer it again.

The clinical record was signed for as given and the SPN confirmed that her practice was to document for the medication as given when she pours the medication which was completed prior to actually administering the medication.

The expectations were confirmed with the Clinical Nurse that medication should not have been left for the resident unattended nor signed for as given prior to administering the medication. Staff were to follow the policy and College of Nurses Standards to ensure policy, procedure, or system, put in place was complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system, put in place was complied with, to be implemented voluntarily.

Issued on this 6th day of August, 2014

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