Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 16, 17, 18, Sep 23, Oct 17, 2011	2011_070141_0020	Complaint

Licensee/Titulaire de permis

MIRDEM NURSING HOMES LTD
176 VICTORIA AVENUE NORTH, HAMILTON, ON, L8L-5G1

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

VICTORIA GARDENS LONG TERM CARE
176 VICTORIA AVENUE NORTH, HAMILTON, ON, L8L-5G1

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

SHARLEE MCNALLY (141)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Supervisor of Programs

During the course of the inspection, the inspector(s) Reviewed Resident's records, homes policy and procedure for Falls Management and Pain Assessment and Management.

H-001568-11

Inspection 2011_070141-0020 for H-001568-11 was conducted simultaneously with inspection 2011-070141-0021 for H-001321-11.
This reports includes findings for written notification related to the O.Reg 79/10 s.170.(3)for inspection 2011-070141-0021 for H-001321-11.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Critical Incident Response

Falls Prevention

Medication

Nutrition and Hydration

Pain

Personal Support Services

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. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.

2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.

3. A missing or unaccounted for controlled substance.

4. An injury in respect of which a person is taken to hospital.

5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not inform the Director of an occurrence for an identified resident that caused the resident to be taken to hospital. The resident had an unobserved fall in 2011. The resident complained of new pain after the fall and was transferred to hospital for further assessment of possible injury. No critical incident related to the fall and transfer to hospital was submitted to the Director. r.107.(3)4

2. The licensee did not inform the Director no later than one business day of an injury causing transfer to hospital for an identified resident. The resident had an unobserved fall in 2011 and a nursing assessment identified an injury. The resident was transferred to hospital on the same day and x-rays confirmed an injury. The critical incident report was not submitted to the ministry for 7 days after the injury. (reference to inspection 2011_070141_0020/H-001568-11). r.107(3)4

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 that the Director is informed no later than one business day after the occurrence of an incident of injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee did not ensure that all physician orders for the administration of a drug for an identified resident was reviewed and reassessed related to resident's condition.
The resident had a medication initiated by the physician in 2011 related to an acute diagnosis. Registered nursing staff placed the medication on hold until direction was received by the physician related to expressed concerns and new tests were ordered by the physician. In 2011 the physician ordered a urine culture and sensitivity test to be completed. The test was never completed and the requisition for testing remained at the nursing station at the time of the inspection. There was no further assessment of the need for the resident to receive the medication and the medication was not discontinued by the physician. s.117.(a)

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 all medical orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in revising the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. An identified resident's identified new pain areas were not assessed using a clinically appropriate assessment instrument when initial interventions were no effective. The resident had a fall in 2011 and subsequently complained of ongoing new pain in an identified location. The resident pain medication was titrated to various types and increased in strengths and frequencies on 3 occasions during one month in 2011. A pain assessment following the home's policy for Pain Assessment and Management was not completed for the resident after these occasions. s.52.(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 when resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following subsections:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee did not ensure that an identified resident had a care conference within six weeks of the resident's admission to discuss the plan of care with the resident or substitute decision-maker. The resident was admitted to the home in 2011 and conference was scheduled for the following month. There is no record in the home to indicate that the conference occurred or had been re-scheduled. Home staff were unable to confirm a conference occurred. The resident substitute decision-maker confirmed there was no conference. s.27.(1)(a)

WN #5: 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 subsections:

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
(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 did not ensure that a medication incident involving an identified resident was documented, assessed, and reported. As per the progress notes the resident received medication for pain after the physician had discontinued the medication. The error was not documented, assessed or reported by the nursing staff administering the drug. The progress notes identify the resident's family member identified the drug issue to the nursing staff administering the drug. The Medication Administration Records did identify the drug had been discontinued and their was no signage of the drug being administered. The home confirmed she had not received a medication error report. r.135.(1)

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. An identified resident did not have a 24-hour admission care plan developed and communicated to direct care staff within 24 hours of his admission to the home.
The resident was admitted in 2011. An admission assessment was not completed for 7 days and there was no record of a 24 hour care plan. The home confirmed there was no record of a plan. The resident had history of falls prior to admission to the home. This risk was not communicated to staff through a care plan and the resident subsequently had a fall 4 days after admission, which caused a transfer to hospital for assessment.
The residents plan of care was not completed until 9 days after admission. s.24.(1)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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. The licensee did not ensure that a drug administered to an identified resident had been prescribed for the resident. The resident had all physician orders for medication for pain discontinued on an identified day in 2011 due to resident diagnosis. The resident's progress notes identified that the resident received pain medication after the medication had been discontinued. s.131.(1)

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. An identified resident did not have care provided as set out in their plan of care. The resident had a history of infections prior to admission. The physician ordered the resident to have a test completed in 2011. The requisition was observed to be at the nursing station during the inspection over one month later and there was no record that the test had been completed. There was no identifying cause for test not being completed. There was no record that the physician was informed that the test was not completed. The resident was admitted to hospital in 2011 for an identified infection. s.6.(7)

Issued on this 28th day of November, 2011

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