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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 27, 2017	2017_640601_0012	005991-17, 007377-17, 007823-17, 007824-17, 007976-17, 009470-17	Complaint

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet LINDSAY ON K9V 5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH LINDSAY ON K9V 4R2

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

KARYN WOOD (601)

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): May 23, 24, 25, 26, 30, 31 and June 2, 2017.

Log(s) #005991-17, log #007377-17, log #007823-17, log #007823-17 and log #009470-17 involving the same resident related to allegations of staff to resident abuse and concerns about personal care.

Log #007976-17 related to allegations of resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Staff (BSO), residents and a family member.

Also during the course of this inspection, the inspector toured the home, observed medication administration, staff to resident interactions, resident to resident interactions, reviewed resident clinical health records, medication incident documentation, applicable policies and the licensee's investigation documentation.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

Related to Log #007377-17

1. The licensee has failed to ensure that staff and others involved in the different aspects of care for resident #001 collaborated with each other in the assessment of the administration of analgesic medication for the resident so that their assessments are integrated, consistent with and complement each other.

During an interview with inspector #601, resident #001 indicated experiencing constant discomfort. Resident #001 indicated the plan of care related to discomfort directs registered staff to administer analgesic as required routinely.

Resident #001 alleged when returning from being off the unit, some of the registered staff would not administer the resident's scheduled analgesic.

Resident #001 indicated being advised by some of the registered staff that if resident #001 required an analgesic, the resident must be present on the unit within a specific time frame of the prescribed times of medication administration.

Resident #001 indicated the need for the analgesic due to ongoing discomfort, however finds it difficult to be on the unit for every scheduled medication time.

Review of resident #001's Physician's Orders by Inspector #601 identified that resident #001 was prescribed an analgesic to be administered four times daily and every four hours in between if required.

Review of resident #001's care plan related to medication administration identified that

resident #001 was requesting to have the as required analgesic offered at regular intervals to assist in maintaining comfort.

Interventions in resident #001's plan of care directs registered staff to look for the resident in a specific location within the home when not on the unit. The registered staff are to hold resident #001's analgesic medication for an identified period of time following the administration time if the resident has not returned to the unit.

If resident has not returned to the unit within the identified period of time, the plan of care directs the registered staff to code the medication administration record as the resident was not available.

Review of resident #001's progress notes for a three month period of time, identified that on a specified date, RPN #104 documented that resident #001 was off the unit and the nurse checked the specific location identified in the resident's plan of care four times.

Review of the resident #001's clinical documentation indicated resident #001 returned to the specific location past the allotted medication administration time period.

In a telephone interview, RPN #104 indicated to Inspector #601 that the physician was not notified when resident #001 had returned past the allotted medication administration time.

RPN #104 also indicated that the regular dosed analgesic medication was not offered to resident #001 because the resident had received the as needed analgesic at a prior time and required four hours between each dose of medication.

Review of clinical documentation and interviews with resident #001 and registered staff did not provide any evidence that staff collaborated with resident #001's physician when the resident did not receive the analgesic on a specified date and time. [s. 6. (4) (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 staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001's medication so that their assessments are integrated, consistent with and complemented each other, to be implemented voluntarily.

WN #2: 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 :

Related to Log #007377-17

1.The licensee has failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

During an interview, resident #001 indicated to Inspector #601, that on an identified date, RPN #113 had administered the resident the incorrect dosage of analgesic medication.

Inspector #601's reviewed the licensee's Medication Incident Notification. On an identified date, RPN #113 had administered to resident #001, a greater dosage of analgesic than prescribed by the physician.

The medication error was discovered by RPN #113 during the narcotic count.

Review of resident #001's Physician's Orders by Inspector #601 indicated resident #001 was to be administered an analgesic at a specifically prescribed dose four times daily.

During an interview with Inspector #601, the ADOC indicated on an identified date, RPN #113 administered to resident #001 another resident's dosage of the same type of analgesic medication in error.

The Physician was notified of the medication incident. The Physician provided instruction to monitor resident #001 and to hold resident #001's morning analgesic medication. [s. 131. (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 drugs are administered to resident #001 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

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Issued on this 27th day of July, 2017

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

Original report signed by the inspector.