Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

# Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée


**Long-Term Care Operations Division**
**Long-Term Care Inspections Branch**

**Division des opérations relatives aux soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 11, 2020 | 2020_694166_0005 | 021692-19 | Complaint |

## Licensee/Titulaire de permis

The Corporation of the City of Kawartha Lakes
26 Francis Streeet P.O. Box 9000 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

CAROLINE TOMPKINS (166)

## 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): January 22, January 23, 2020.**

**A complaint related to resident care was inspected.**

**During the course of the inspection, the inspector(s) spoke with Registered Nurse (RN), Registered Practical Nurse (RPN), Behaviourial Support Ontario (BSO), Personal Support Worker (PSW), Registered Dietitian (RD), Associate Director of Care (ADOC), Executive Director (ED).**

**During the course of this inspection, the Inspector reviewed the clinical health records and progress notes related to the care and treatments for resident #001.**

**The following Inspection Protocols were used during this inspection:**
**Nutrition and Hydration**
**Personal Support Services**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Director received a complaint from resident #001's Substitute Decision Maker (SDM) related to the SDM not being advised of specified medications that had been ordered and specified medications that had been discontinued for resident #001.

During a telephone interview with Inspector #166, resident #001's SDM indicated, that prior to resident's admission to the home, resident #001 had been prescribed three medications that had been specifically ordered by a medical specialist. The SDM indicated that these medications were discontinued without the knowledge of the SDM.

Review of the medication quarterly review for resident #001, indicated that on a specified date, two of the medications had been discontinued. Review of progress notes did not provide documented evidence that the orders to discontinue these medications had been communicated to resident #001's SDM.

Review of physician's orders, on a specified date, indicated that another of the resident's previously ordered medications had been discontinued. Review of progress notes did not provide documented evidence that the order to discontinue the medication had been communicated to resident #001's SDM.

During an interview with Inspector #166, RN #100, indicated that on the physician's order sheet there is a section that is to be initialed by a registered staff if consent has been given for any changes or additions to medications or treatments ordered by the physician. Review of the physician's orders to stop the was not initialed by a registered staff. In the section labeled consent an X is marked.

Review of physician's order sheet dated on a specific date indicated:
- Do not change/add or discontinue any medications as per SDM.

During an interview with the ADOC and review of resident #001's progress notes, indicated that the ADOC had met with resident #001's SDM to discuss resident #001's care and treatments. The discussion also included an understanding and agreement that no further changes to medications would occur unless communicated to the resident's SDM.

The licensee has failed to ensure that the SDM for resident #001 had been provided the opportunity to participate fully in the development and implementation of the plan of care related to the discontinuing of specific identified medications. [s. 6. (5)]

***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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.***

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**Issued on this 18th day of February, 2020**

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

**Original report signed by the inspector.**