



Ministry of Health and
Long-Term Care

Ministère de la Santé et des
Soins de longue durée

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

Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée

Health System Accountability and
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Performance Improvement and
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Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la
performance et de la conformité

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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
Jun 3, 2014	2014_292553_0014	870-13,073- 14,894-13	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Street, 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

MATTHEW STICCA (553)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 14,15,16 2014.

The following logs were addressed during this inspection: Log # O-000894-13, O-000870-13, and O-000073-14

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Residents and Family members.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health care records, reviewed the home's policy on bowel management.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Falls Prevention

Medication

Pain

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.



NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>



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. (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 :

1. Regarding Log #O-000870-13

Critical Incident submitted to MOHLTC. It was noted in the Critical Incident Report that Staff did an "inadequate assessment" of resident and then determined that they would not follow the resident's bowel protocol.

Review of Resident #001 Care plan indicated the following:

Resident #001 had a known history of constipation concerns. The care plan identified this and had goals and interventions to address that concern. Interventions that included following a bowel protocol as prescribed by the physician.

Resident #001 was charted on their ADL PSW flow sheets as not having had a bowel movement in 5 days. Staff #101 recorded on Resident #001's medication administration record as well as the progress notes for receiving 30mLs of lactulose, which was not in accordance with the directions outlined by the physician. [s. 131. (2)]



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Issued on this 3rd day of June, 2014

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

MATTHEW STICCA #553