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
Feb 13, 2017	2016_535557_0017	033759-16	Resident Quality Inspection

Licensee/Titulaire de permis

VICTORIA VILLAGE INC.
76 ROSS STREET BARRIE ON L4N 1G3

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

VICTORIA VILLAGE MANOR
78 ROSS STREET BARRIE ON L4N 1G3

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

VALERIE PIMENTEL (557), JENNIFER BROWN (647)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 13, 14, 16, 19, 20, 21 and 22, 2016.

The following complaints were inspected concurrently:
Log #026887-16 related to safe and secure home, personal support services, responsive behaviors, dining and snack services, medication error and duty to protect, and
Log #005699-14 related to abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Housekeeper.

During the course of the inspection, the inspectors conducted observations of residents and home areas, staff and resident interactions, provision of care, medication administration, infection prevention and control, reviewed clinical health records, staffing schedules/assignments, minutes of Residents' Council meetings, minutes of relevant committee meetings and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

In December 2016, the inspector observed on an identified floor the electronic medication administration record (eMAR) screen on the medication cart open on the home screen page listing the residents who were to receive 1200 hour medications. There were no registered staff present. An identified registered staff member was observed in the dining room. The inspector observed the medication cart for approximately one minute until the identified registered staff member returned to his/her medication cart. In the vicinity of the medication cart there were residents' wandering in the hallway.

Interview with the identified registered staff member when asked about maintaining the residents privacy and confidentiality by leaving the screen unlocked and not in attendance replied the screen should be locked to protect resident privacy.

In December 2016, on the same identified day, the inspector observed on three other identified floors the eMAR screen open on the medication cart and the home screen page listing the residents who were to receive 1200 hour medications. There were no registered staff present.

Interviews with three identified registered staff members, one from each of the three identified floors all confirmed the eMAR screen is to be locked and not left open when they are not at the medication cart and further validated that they were not protecting the residents privacy and maintaining confidentiality.

An interview with the Associate Director of Care (ADOC) confirmed it is an expectation that all staff maintain the residents personal health information and to ensure the home page screen is locked on all computers when not in use. [s. 3. (1) 11. iv.]

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 every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure all hazardous substances are labelled properly and kept inaccessible to residents at all times.

The Director received a letter dated in August 2016, from a complainant which had indicated that in July 2016, an identified resident potentially consumed a hazardous substance from an open bottle that had been found in his/her room. He/She subsequently had been transferred to hospital for assessment and later discharged without requiring treatment.

Policy reviewed titled Safety Guidelines, last revised September 2013, under "guidelines" #19, states "do not leave chemicals unattended".

Interview with an identified staff member indicated that he/she had left a hazardous substance unattended in the resident's room and therefore it had been accessible to residents.

Interview with ADOC indicated that the hazardous substance that had been left in the resident's room unattended placed all residents at risk and therefore did not ensure that all residents were protected from unnecessary harm and or injury. The ADOC further confirmed that all hazardous substances are required to be kept in a locked location at all times and further confirmed that all hazardous substances are to be inaccessible to residents at all times. [s. 91.]

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 all hazardous substances are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

In December 2016, the inspector observed the medication cart unlocked on an identified floor and no registered staff present.

Interview with an identified registered staff member confirmed he/she had left the medication cart unlocked and that he/she knew it was to be kept locked at all times.

In December 2016, the inspector observed the medication cart on another identified floor unlocked and a medication cup containing 30 milliliters (ml's) of a liquid substance observed sitting on the top of the medication cart and no registered staff present.

Interview with an identified registered staff member confirmed the identity of the liquid substance and confirmed he/she had the left the medication cart unlocked and that he/she knew it was to be kept locked at all times. He/she further stated that no forms of medication are to be left unattended and unsupervised.

In December 2016, the inspector observed on another two identified home areas the medication cart unlocked no registered staff present.

Interviews with two other identified registered staff members confirmed they had left the medication carts unlocked and that they knew it was to be kept locked at all times. One of these two identified registered staff member confirmed further that the medication drawer was broken and would not latch shut when the drawer closed on one of the identified carts. He/she was going to call the pharmacy to repair the locking mechanism.

Interview with ADOC confirmed that it is the home's expectation to ensure the medication carts are kept locked at all times to ensure the safe storage of medications. [s. 130. 1.]

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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #4: 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. (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 has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

The Director received a letter dated in August 2016, from a complainant which had indicated that in March 2016, an identified resident had been given his/her scheduled medication at 0830 hours and a co-resident's medication at 0900 hours.

Review of the eMAR and progress notes in March 2016, indicated that the identified resident had been prescribed and had received his/her own nine scheduled medications, in addition the identified resident, received another co-resident's four prescribed medications at 0900 hours. There were no ill effects to either residents.

An interview with an identified registered staff member indicated that he/she gave the identified resident's medication while he/she had been sitting in the dining room. The identified registered staff member further indicated that he/she returned to the medication cart to prepare additional medications for the co-resident and when he/she returned to the dining room table he/she accidentally administered them to the first resident whom had already received his/her own medication and had been sitting at the same table as the co-resident.

Interview with ADOC confirmed that no drug is to be administered to a resident in the home unless the drug has been prescribed. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

The Director received a letter dated in August 2016, from a complainant which had indicated that in an identified month, an identified resident did not have their upper denture in his/her mouth.

The written care plan and kardex identified the following:
- upper full denture.
- staff are to clean and soak dentures with a denture tablet, resident will often be non-compliant but staff to continue to reapproach, and
- one staff assistance is required.

Interview with an identified staff member confirmed the resident has an upper plate only and it is sometimes very difficult to get the upper plate in his/her mouth. The identified staff member further stated that when the resident refuses they will leave and reattempt later. He/she also stated they use polygrip to ensure the resident leaves the upper plate in his/her mouth. Review of the written care plan and kardex with the identified staff member confirmed there were no directions to apply polygrip to the upper plate to keep

in place.

Interview with an identified registered staff member confirmed he/she did not know that identified resident used polygrip to ensure his/her upper plate stayed in place. Both identified staff members confirmed the plan of care did not give clear instructions to apply polygrip to the identified resident's upper plate.

Interview with the director of care (DOC) confirmed the plan of care did not provide clear direction to the direct care providers instructing them to apply polygrip to the identified resident's upper plate. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when care set out in the plan has not been effective.

The Director received a letter dated in August 2016, from a complainant which had indicated that on multiple occasions an identified resident was observed to have identified responsive behavaiours.

The written care plan and kardex indicated to use a wander guard strip on the identified resident's doorway when ever necessary.

In December 2016, the inspector observed a resident sleeping in another resident's bed. An identified staff member attempted to get this resident out of the other resident's bed without success. There was no wander guard observed in the doorway of resident's room. When asked where it was the an identified staff member responded he/she didn't know.

Interview with an identified registered staff member confirmed the wander guard identified to use it only when necessary and that it should be used at all times and maybe they should use the electronic wander guard system that sets off an alarm when someone enters the identified room. He/she confirmed that the current plan of care was not effective as the identified resident still goes into co-resident's bed. The an identified registered staff member was going to follow-up with the restorative care program lead about obtaining an electronic wander guard.

An interview with the DOC confirmed the care set out in the plan was not effective as resident #014 continues to enter resident #013's room and will be reviewed and revised.

[s. 6. (10) (c)]

Issued on this 15th day of February, 2017

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

Original report signed by the inspector.