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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 2, 2019	2019_782736_0007	005920-19	Follow up

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

AMANDA BELANGER (736), TRACY MUCHMAKER (690)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 23-26, 2019.

One intake was inspected during the course of this Follow Up inspection:
-the intake was related to CO#001 from Inspection Report #2019_746692_0007, r. 129(1) of the Ontario Regulations 79/10, specific to the safe storage of medications.

Critical Incident inspection #2019_782736_0009 and Complaint inspection #2019_782736_0008 were conducted concurrently with this Follow Up Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing Services (DONS), the Associate Director of Nursing Services (ADONS), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and, the Clinical Consultant Pharmacist.

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, including the administration of medications, reviewed training documents, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #001	2019_746692_0007	690

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	Légende 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. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the condition of the Long Term Care Home Act (LTCHA) that the licensee shall comply with every order made under the Act.

On March 15, 2019, compliance order (CO) #001 from inspection number 2019_745692_0007 made under O. Reg. 79/10, s. 129 (1), related to the safe storage of medications. The licensee was ordered the following:

The licensee must be compliant with r. 129 (1) of the Ontario Regulation 79/10.

Specifically, the licensee shall:
1. Develop and implement a process to ensure that all controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;
2. Ensure that all registered staff are trained on the process of storing all controlled substances;
3. Maintain a record of the training provided, including dates, times, attendees, trainers and material taught.

The compliance due date was April 12, 2019.

The licensee failed to be compliant with step 3 of the order, specifically, to maintain a record of the training provided, including dates, times, attendees, trainers and material taught.

In separate interviews with Inspector #690, four Registered Practical Nurses (RPNs) (#104, #106, #109, and #115) indicated that they attended an in service provided by the home's Clinical Consultant Pharmacist (CCP) and received education on the change in process related to the storage and counting of controlled substances. Inspector #690

asked an additional five registered staff (Registered Nurse (RN) #108, RN #110, RPN #103, #105, and #111) if they had attended an education in service on the change in process for safe storage of controlled substances. They indicated that they had received an email from the Director of Nursing Services (DONS) about the new process, that they did not attend an in service or confirm that they had received the education.

In an interview with Inspector #690, the DONS indicated that five registered staff had attended an in service on the new process for storage of controlled substances, and that all other registered staff had received an email to inform them of the change. The DONS identified that they had no way of knowing if the registered staff received the email regarding the new process for storage of controlled substances. The DONS further indicated that they did not keep a record of training including the date, time, attendees, the trainer and the material taught and that they should have. [s. 101. (3)]

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 comply with every order made under this Act, to be implemented voluntarily.

Issued on this 3rd day of May, 2019

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

Original report signed by the inspector.