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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 10, 2017	2017_569508_0013	021219-17	Complaint

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD DUNDAS ON L9H 5G7

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

ROSEANNE WESTERN (508)

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): October 17, 27 and October 30, 2017.

This inspection was conducted as an off-site complaint inspection - log #021219-17, related to pain management and medication incidents. During this inspection, the Long Term Care (LTC) Homes Inspector reviewed the resident's clinical records.

During the course of the inspection, the inspector(s) spoke with the Convalescent Care Program Lead.

The following Inspection Protocols were used during this inspection:
Medication
Pain

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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan was not effective.

Resident #001 was admitted to the home in the morning of an identified date in 2017, after suffering an injury earlier that month.
The resident’s prescribed medication list was received by the home, reviewed by the home’s physician and faxed to the pharmacy the same morning.

The resident was prescribed two identified medications to manage their pain. One medication was a regularly scheduled medication to be administered twice a day (BID) and the other medication was to be administered every four hours when needed (PRN). The pharmacy faxed back a list of medications that were not covered by the resident's plan which included the PRN medication.

The pharmacy required the resident’s consent to pay for the identified medications prior to sending to the home.

Review of the resident’s clinical record indicated that on the afternoon on the day of admission, the resident complained of pain. The resident requested something for pain several times but it was documented that registered staff did not have the PRN medication available to administer to alleviate the resident's pain.

The Registered Practical Nurse (RPN) documented that during this time the resident stated that they would pay for this medication if they needed to as it was the only medication that would alleviate their pain and requested it be sent as soon as possible. No further actions were taken.

Later that night, it was documented at an identified time, that the resident was complaining of unrelieved pain. The RPN informed the resident that their pain medication was not available and gave the resident an alternative medication. This was not effective and the resident indicated that they could not sleep.

The following day, the resident inquired about their medications again and was informed that the Social Service Worker (SSW) was following up about which medications could be covered despite the resident already agreeing to pay for the PRN medication.

A review of the Responsive Behaviour Incident report completed on an identified date, revealed that resident #001 became physically and verbally responsive towards staff. The documentation indicated that the triggers/contributing factors were identified as the resident not receiving pain medication. It was documented that staff did not have other residents on the same medication “to borrow from”.

Later that evening after the Social Service Worker (SSW) confirmed that the resident’s PRN medication was not covered by insurance, the SSW again informed the resident. It was also documented at this time that the resident had previously agreed to pay for it but the medication was not available for the resident.

During discussions held with the Convalescent Care Program Lead on October 30, 2017, it was confirmed that the home should have ordered the medication or utilized the home’s back up pharmacy to ensure the resident’s medications were available to the resident. It was also confirmed that during the time the resident was experiencing unrelieved pain, staff at the home failed to offer alternatives to manage the resident’s pain.

It was confirmed during record review and during an interview with the Convalescent Care Program Lead on October 30, 2017, that the licensee failed to ensure that when the resident was reassessed, the plan of care was not reviewed and revised when care set out in the plan of care was not effective.

Please note: This area of non-compliance was identified during an off-site complaint inspection (log #021219-17). [s. 24. (9) (c)]

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 residents are reassessed and the plan of care reviewed and revised when care set out in the plan is not effective, 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 :

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

Resident #001 was admitted to the home on an identified date in 2017, for convalescent care after suffering an injury.
On an identified date in 2017, resident #001 reported to staff that they were upset due to not receiving their pain medication that was scheduled for 2400 hours and again at 0400 hours.

After review of the electronic medication administration record (E-mar), registered staff discovered that the resident did not receive their medications as ordered. The resident received another pain medication that was ordered to be administrated at 0800 hours and 2000 hours instead of the prescribed medication for 2400 hours and 0400 hours.

The resident was scheduled to have their pain medication administered again at 0800 hours; however, it was held due to the medication error an alternative medication was administered instead.

It was confirmed during record review and during an interview with the Convalescent Care Program Lead on October 30, 2017, that the licensee failed to ensure that drugs were administered to the resident in accordance with the directions for use specified by the prescriber.

Please note: This area of non-compliance was identified during an off-site complaint inspection (log #021219-17). [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 residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 15th day of November, 2017

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

Original report signed by the inspector.