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 sions 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
Mar 21, 2016	2016_286547_0003	002753-15/001190-16	Complaint

Licensee/Titulaire de permis

GENESIS GARDENS INC
438 PRESLAND ROAD OTTAWA ON K1K 2B5

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

FOYER ST-VIATEUR NURSING HOME
1003 Limoges Road South Limoges ON K0A 2M0

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

LISA KLUKE (547)

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): February 9,10,11 2016

This inspection was conducted regarding two complaint log's:#002753-15 related to Nursing and Personal Support Services and Nutrition and Hydration programs and #001190-16 regarding hospitalization and change in condition and plan of care.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physiotherapy Assistant (PTA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Residents and Family Members.
In addition the inspector reviewed resident health care records, reviewed the home's policy and procedure for Medication Reconciliation and observed aspects of resident care and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, procedure or system put into place was complied with. In accordance with O. Reg. 79/10, s. 114(2) every licensee of a long-term care home shall ensure that the written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. This inspection was related to complaint log #001190-16.

The home had a Medication Reconciliation policy and procedure for accurate and complete transfer of medication information at transitions of care, intended to prevent medication errors. This policy and procedure was last reviewed August 2015, which was identified by the Assistant Director of Care (ADOC) as the current procedure in place to direct Registered Nursing staff for all re-admissions from acute care hospitals for medication reconciliation.

Page 2 of this procedure stated the following: "Identifying any discrepancies and if any are found, bringing them to the attention of the prescriber and making appropriate changes to the orders". This process further indicated to "compare the medication history to transfer/discharge orders to ensure that the resident's medication were reconciled at transfer/discharge".

Inspector #547 reviewed resident #002's health records and noted a copy of a six page fax provided to the home on a specified date in December, 2015, the day before the resident was discharged from Hospital. This fax contained a Discharge Care Plan by the hospital attending physician dated this same date in December, 2015 that did not include a specified medication which was identified on the hospital's Medication Administration Record(MAR) sent in this same fax communication from the hospital. The medication reconciliation form that RPN #100 completed on this same specified date in December, 2015, after receiving this fax from the hospital, did not include the resident's specified medication or any progress note to indicate any inquiry into this discrepancy.

Inspector #547 interviewed RPN #100 on February 11, 2016 who completed this medication reconciliation for this resident's planned return from hospital, and indicated that she followed the Discharge Care Plan the hospital sent and that she had not noticed the medication discrepancy regarding the specified medication on the hospital MAR.

The ADOC indicated to Inspector #547 that Resident #002 arrived to the home on

another specified date in December, 2015 with the hospital discharge summary dictated for the attending physician on the date of discharge in December 2015. This discharge summary stated on page 2 of 3 that Resident #002 was started on a trial of this specified medication and did very well. This same specified medication was listed as the first medication on the list of Discharge Medications. Another copy of the MAR was also sent with the resident that indicated that the resident was receiving this specified medication at discharge from hospital.

Interview with ADOC and DOC in the home on February 11, 2016 indicated that they had missed this medication during the reconciliation for re-admission from hospital on the date of discharge in December 2015. The resident did not receive this medication for a period of 27 days, which confirmed that the procedure related to Medication Reconciliation was not complied with. [s. 8. (1)]

Issued on this 21st day of March, 2016

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

Original report signed by the inspector.