Ontario

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 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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Aug 19, 2019	2019_704682_0020	006625-19	Complaint

Licensee/Titulaire de permis

Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

AILEEN GRABA (682)

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): August 13, 14, 2019.

The following complaint inspection(s) was conducted: log # 006625-19 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Director, Director of Clinical Services (DOCS); registered staff; personal support workers (PSW) and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, complaint log/binder, medication incidents, meeting minutes, policy and procedures and observed residents and medication storage.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	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 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 resident #002 in accordance with the directions for use as specified by the prescriber.

A complaint was submitted to the Director on an identified date.

According to the clinical records, on an identified date, resident #002 was prescribed a medication for a health condition, to be administered at a certain time of day. Further clinical record review indicated that on identified dates, the medication was signed as 'drug not available' by registered staff #105.

A review of progress notes indicated that on identified dates, staff #101 documented that they had informed the Director of Clinical Services (DOCS) and that they were still investigating the incident on the identified date.

During an interview, staff #101 stated that the medication was not available. During an interview, the DOCS confirmed that they were aware that the medication was not available on the identified dates. The DOCS confirmed that they investigated the incident. The DOCS confirmed that on those identified dates, resident's #002 medication was not administered in accordance with the directions for use as specified by the prescriber. [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 as specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's #002 substitute decision-maker (SDM) was given an opportunity to participate fully in the development and implementation of resident's #002 plan of care.

A complaint was submitted to the Director.

According to the home's medication documentation system and resident #002 clinical records, they were prescribed a medication for a health condition. A review of the clinical records included a progress note, staff #102 documented that resident #002 SDM was not aware of the medication order made on an identified date.

During an interview, staff #102 confirmed that the SDM had identified that they were not aware of the change made to resident's medication on an identified date. During an interview, the DOCS confirmed that staff were to inform the resident and/or SDM of medication changes. The DOCS acknowledged that the SDM was not given an opportunity to participate fully in the development and implementation of the residents #002 plan of care. [s. 6. (5)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving resident #002 was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A complaint was submitted to the Director.

According to resident #002 clinical records, they were prescribed a medication for a health condition that was to be given at a prescribed time. Further clinical record review indicated that on identified dates, the medication was signed as 'drug not available' by registered staff #105. A review of resident #002 progress notes indicated that staff #101 had informed the DOCS and that they were still investigating the incident. A review of the home's medication incident documentation system did not include a medication incident with immediate actions related to the unavailability of the prescribed medication on the identified dates.

During an interview, staff #101 stated that they did not find the medication on the identified date. During an interview, the DOCS confirmed that the medication was not available on the identified dates. The DOCS acknowledged that they expected staff to complete a medication incident when they identified resident #002 medication was not available. The home did not ensure that every medication incident involving a resident was documented, together with immediate actions taken to assess and maintain the resident's health. [s. 135. (1)]

Issued on this 20th day of August, 2019

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

Original report signed by the inspector.