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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 18, 2013	2013_184124_0020	O-000808-13	Complaint

Licensee/Titulaire de permis

PROVIDENCE CARE CENTRE
340 Union Street, KINGSTON, ON, K7L-5A2

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

PROVIDENCE MANOR
275 SYDENHAM STREET, KINGSTON, ON, K7K-1G7

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 13 and 16, 2013

During the course of the inspection, the inspector(s) spoke with Residents, the Administrator/Vice President Long Term Care, Director of Care, Dietitian, Registered Nurse, Registered Practical Nurse and Personal Support Workers.

During the course of the inspection, the inspector(s) completed a walking tour of the home area, observed staff-resident interactions, made general observations of resident care and reviewed the resident's health record.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dignity, Choice and Privacy

Medication

Pain

Personal Support Services

Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. 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 Resident #1 received drugs in accordance with the directions for use specified by the prescriber.

Resident #1 has a diagnosis of arthritis and a history of pain.

On a specific date, Resident #1's physician documented that Resident #1 stated that the Tylenol controlled the pain.

Six days later, a Registered Practical Nurse documented that Resident #1 requested and was given Tylenol at 1700 hours and 2120 hours to keep ahead of the pain.

The following day, Resident #1's physician wrote an order that stated Tylenol 500mg two tablets every four to six hours while awake, to a maximum of four grams per day. When this order was transcribed by the registered nursing staff specific times for the administration of the Tylenol were assigned; 0800 hours, 1400 hours, 1800 hours and 2400 hours. On this day, Resident #1 received Tylenol at 1400 hours, 1800 hours and 2400 hours.

The next day at 0600 hours it is documented that Resident #1 requested Tylenol and was advised by registered staff that Tylenol could not be given as there was no PRN order and it was ordered for 0800.

Staff #100 indicated that the physician's order needed clarification and was surprised that specific times were recorded. Staff #100 indicated that Resident #1 could have had Tylenol at 0600 hours because the resident's previous dose was administered at 2400 hours the previous day, six hours before.

Resident #1 did not receive Tylenol for pain in accordance with directions for use by the prescriber. [s. 131. (2)]

2. Resident #1 reported to the inspector that he/she has history of constipation and diverticulitis and expressed concern regarding the care given for constipation.

The Medical Directives Laxative Routine directs staff to administer Milk of Magnesia on Day #3 without bowel movement, on Day #4 if the Milk of Magnesia was ineffective, staff are to administer Senokot and on Day #5 if the Senokot was ineffective, staff are to give a glycerin suppository in the morning or a Fleet enema as

needed.

A review of Resident #1's Bowel Function Record for one month showed that the resident had a bowel movement one day and then five days later. There is no clinical documentation to indicate that Resident #1 received Milk of Magnesia on day #3 or Senokot on day #4.

A review of Resident #1's Bowel Function Record for the next month, showed that the resident had a bowel movement one day and then one six days later. It is documented on the Medication Administration Record that the resident received Lactulose on day #3. There is no clinical documentation to indicate that the resident received Senokot on day #4 or a glycerin suppository or fleet enema on day #5.

The resident's Bowel Function Records and Medication Administration Records were reviewed with Staff #100 who stated that there should have been interventions on the identified dates. [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 Resident #1 receives drugs in accordance with the directions for use 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. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to immediately forward a written complaint concerning the care of Resident #1 to the Director.

On September 16, 2013, the Administrator/Vice President Long Term Care reported that Resident #1's Power of Attorney submitted a letter of complaint received by the home on May 31, 2013.

The Administrator/Vice President of Long Term Care indicated that this letter of complaint concerning the care of Resident #1 was not forwarded to the Director. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed at a minimum twice a week.

Resident #1 has a diagnosis of arthritis.

Resident #1 expressed concern that he/she was not receiving two baths per week. The resident's Personal Care and Observation Flow Sheets, progress notes and Bath Sheets were reviewed and indicated that Resident #1 received seven of the eight baths scheduled one month, five of the eight scheduled baths the next month, seven of nine baths scheduled for the third month and seven of the nine baths scheduled for the fourth month.

Staff #102, #103 and #105 indicated that Resident #1 may not have had her bath because of staffing.

Resident #1 was not bathed at a minimum twice a week. [s. 33. (1)]

Issued on this 20th day of September, 2013

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

Cindi Bard for Linda Hamilton