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 le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 19, 2018;	2017_491647_0019 (A1) (Appeal\Dir#: DR# 075)	025118-17	Resident Quality Inspection

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

Ontario

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PHILIP MOORMAN (Director) - (A1)(Appeal\Dir#: DR# 075)

Amended Inspection Summary/Résumé de l’inspection modifié

NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector’s order(s): CO#002.
The Director’s review was completed on January 17, 2018.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director’s review DR# 075.
A copy of the Director Order is attached.

Issued on this 19 day of January 2018 (A1)(Appeal\Dir#: DR# 075)

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

Original report signed by the inspector.

Ontario

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PHILIP MOORMAN (Director) - (A1)(Appeal/Dir# DR# 075)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 6, 7, 8, 9, 14, 15, 16, 2017.

The following critical incidents (CI) were inspected concurrently with this inspection:

020023-15: related to abuse,

The following complaints were inspected concurrently with this inspection:

006353-15: related to refusal of admission to the home,

025571-17: related to refusal of admission to the home,

018765-17: related to refusal of admission to the home,

002153-17: related to refusal of admission to the home,

018769-17: related to refusal of admission to the home,

027288-17: related to refusal of admission to the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (CoDOC), Director of Resident and Family Services, Registered Nurses (RN), Registered Practical

Nurse (RPN), Personal Support Workers (PSW), Residents, Family Members, and Substitute Decision Makers.

During the course of the inspection, the inspectors conducted observation in resident home areas, observation of care delivery processes including medication passes and meal delivery services, and review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 VPC(s)**
- **2 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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the Resident Quality Inspection (RQI) and the inspection of handling of medication incidents and adverse drug reactions, inspector #557 reviewed the following medication incident report for resident #036.

Review of the electronic medication administration record (eMAR) for an identified date, indicated that resident #036 had been prescribed an identified medication and had been administered the identified medication on the date of the incident.

On the above mentioned identified date, a medication incident report was completed identifying the administration of identified medications to resident #036 that were not prescribed for the resident.

Record review of resident #036's progress notes confirmed that he/she received resident #034's drugs. A further record review indicated the home contacted poison control and the physician who suggested to transfer resident #036 to the hospital for medical assessment. Resident #036 returned back to the home with a physician's order to resume all previously prescribed medications.

Review of the physician order's and the eMAR confirmed that resident #036 did not have a physician order for the above identified drugs.

Interview with Registered staff member #104 confirmed he/she did administer the above identified drugs to resident #036 on an identified date. He/she further explained that it was a mistake and that particular day he/she was very busy and knows that he/she should go slower even if busy so that mistakes don't happen.

The home's policy in Medical Pharmacies manual, The Medication System, The Medication Pass, policy #3-6, dated February 2017, identified the following: to find the identified resident's eMAR and identify the medications the resident is to receive at the pass, to check each medication label against the eMAR for accuracy, and administer the medications.

Interview with the Director of Care (DOC) confirmed resident #036 received resident #034's medication on an identified date. He/she met with Registered staff member #104 and reviewed the medication error with him/her and provided

counseling. He/she further confirmed that the Registered staff member #104 completed a personal learning plan in regards to medication administration. The DOC confirmed it is the home's expectation that that no drug is administered to a resident in the home unless the drug has been prescribed for the resident by the registered staff. [s. 131. (1)]

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

During the RQI, the home's medication and adverse drug reaction incident reports for an identified three month period, were reviewed.

On an identified date, a medication incident report was completed for resident #035 identifying the administration of a medication. Resident #035 was to receive an identified dose of medication however, he/she received more medication than the prescribed dose.

During the course of the inspection the inspector was unable to reach the identified Registered staff member #140, who was involved in the above identified incident.

Review of the homes investigation notes and an interview with the DOC confirmed he/she spoke with the identified Registered staff member and reviewed the medication error with him/her. The Registered staff member's explanation was that he/she completed an assessment of resident and that he/she administered the incorrect amount of identified medication.

The DOC confirmed it is the home's expectation that medications are administered as prescribed to all residents with in the home and that resident #035 did receive the incorrect amount of an identified medication.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was minimal harm and or potential harm and or risk, and the home had previously been issued a voluntary plan of correction (VPC) as part of inspection 2016_535557_0017 on December 13, 2016, for this legislation. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,

(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

This inspection had been initiated related to complaints received by the Ministry of Health and Long Term Care (MOHLTC) relating to intakes #006353-15, #025571-17, #018765-17, #002153-17, #027288-17 and #018769-17, as they related to applications for admission to the home and being refused by the licensee.

During an interview with the Community Care Access Centre (CCAC) coordinator, it had been indicated that resident's #012, #013, #014, #015, #075, and #076, had submitted an application for admission to the home and had been refused.

Record review of the involved resident files indicated:

The six identified applicants applied for admission to the home during an identified period of time. The home had responded in writing to the substitute decision maker and stated “Our staff lacks the nursing expertise necessary to meet the care requirements. Client’s care requirements exceeds our abilities which will have a negative impact on quality of residents."

During an interview with the DOC, he/she had indicated that the refusals of the above six applicants had been based on the cost of administering their health care needs. The DOC confirmed during the interview that refusal of the above mentioned applicants for admission did not meet the above mentioned criteria in the legislation.

During an interview with the Administrator, he/she acknowledged staff have the expertise to care for the above identified applicants. The Administrator, indicated that the above mentioned applicant refusals, had been based on the cost associated with the needs of these applicants. The Administrator further stated that the home is currently over budget and would not be accepting these above mentioned applicants for admission.

A compliance order will be served to the home based on the scope, which is widespread as it has the potential to affect a large number of the home's applicants; and the severity of the non-compliance has the potential to negatively affect the residents waiting for long term care home admission. There is no previous compliance history for this legislative reference. [s. 44. (7)]

Additional Required Actions:

(A1)(Appeal/Dir# DR# 075)
The following order(s) have been rescinded:CO# 002

WN #3: 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, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Under O.Reg 79/10, s. 114 (1) (2), 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.

Policy group 1:
Medical Pharmacies manual, Monitored Medications, Shift Change Monitored Drug Count, policy #6-6, dated February 2017, identified the following: two staff (leaving

and arriving) together count the actual quantity of medications remaining, record the date, time, quantity of medication and sign in the appropriate spaces on the Shift Change Monitored Medication Count form, and confirm the actual quantity is the same as the amount recorded on the Individual Monitored Medication Record. If discrepancies found report these the Nurse Manager and DOC immediately.

Nursing Administration, Narcotic Count, Policy #V1-J-40.46, original date November 2013, identified the following: the inventory counts of controlled substances will be conducted between shifts in order to maintain accurate inventory and quickly and effectively identifying missing medications or potential risks.

Nursing Administration, RN Night Shift Routine, Policy #V1-C-40.00(c), review date of November 2015, Nursing Administration, Care Leader/RPN Night Shift Routine, Policy #V1-C-50.00(c), review date of November 2015, Nursing Administration, Care Coordinator RN Day Shift Routine, Policy #V1-C-40.00(a), review date of November 2015 and Nursing Administration, Care Leader/RPN Day Shift Routine, Policy #V1-C-50.00(a), review date of November 2015, identify for the registered staff to complete a narcotic count with the registered staff of oncoming or off going shift.

During the RQI and during the course of the medication inspection and observation of the narcotic and controlled substances, on an identified date, identified time, and on an identified home area, the inspector and Registered staff member #112 reviewed the Narcotic Ward Drug Count sheet to ensure that two staff signed this record at the change of shift and that the individual Monitored Medication Record for 7-Day Card (MMR) count sheet were accurate with the individual resident's blister packs. During this observation the inspector observed the count for an identified resident was not accurate and it appeared there was one tablet of an identified medication missing.

The inspector observed that there was a discrepancy noted on an identified date. The balance of the identified resident's medication was an identified amount. At an identified time, Registered staff member #128 made a note identifying the resident was sleeping and the count remained at an identified amount. The identified resident received his/her identified medication, which adjusted the count of the identified medication. The student nurse (SN) #111 administered the identified medication at an identified time which adjusted the count to the identified amount. The resident's medication package contained only one tablet, therefore there was

one tablet of the identified medication missing.

Interview with Registered staff member #112 identified he/she did not count the narcotics and controlled substances with the off going shift, and had accepted what was documented as being accurate. He/she said that is the way the home counts the drugs from an identified shift to another and further explained it is the two registered staff on an identified shift that do the count. He/she indicated that is not how he/she was taught but that is what the home does and approves.

Interview with the resource nurse and the assistant director of care (ADOC) confirmed that the two registered staff from an identified shift count together and the oncoming registered staff is supposed to do their own count and verification and then sign inside the box.

Interview with the DOC confirmed the homes practice and policies do not match and the home will have to investigate and discuss with pharmacy to ensure policies match home practice.

Policy group #2:
Medical Pharmacies manual, Handling of Medication – Drug Destruction and Disposal, policy #5-4, dated February 2017, identified the following: Medications are considered destroyed when they are altered to such an extent that their consumption is rendered impossible or improbable. Under title of documentation the policy further identifies a Shift Change Monitored Count form is used to double sign medication out of storage, two nurses will be accountable to complete and double sign medication onto Drug Destruction and Disposal form and then place the medication into storage until destruction takes place.

During the RQI and during the course of the medication inspection and observation of the narcotic and controlled substances, on an identified date, the inspector observed the narcotics and controlled substances blister packs to the Monitored Medication record for 7-Day Card for an identified resident, the record identified there were two tablets of an identified medication unaccounted for. An interview with Registered staff member #112 confirmed the identified medication was administered to the identified resident by SN #111 and he/she had not signed the Monitored Medication record for 7-Day Card. After the explanation by Registered staff member, he/she confirmed there was one tablet of the identified medication missing. Registered staff member #112 realized there was an error or mistake of some kind and called for the resource nurse and the ADOC for assistance.

Record review of the Monitored Medication record for 7-Day Card for an identified resident for an identified date and time, revealed there were five tablets of the identified medication remaining. At an identified time, Registered staff member #128 identified there were five tablets remaining, he/she wrote a note on the Monitored Medication record for 7-Day Card for the identified resident identifying that the resident was sleeping. He/she did not identify that he/she had wasted the identified medication, nor was there a second signature on the 7-Day record confirming a dose as being wasted or destroyed and the count remained at five.

Record review of the progress notes on an identified date and time, identified Registered staff member #128 wrote a note indicating the resident was sleeping and unable to arouse under the eMAR medication administration note. The entry did not clarify whether the identified resident received his/her identified medication as he/she was sleeping and it was not administered. The entry in the progress note was made at an identified time, which had been, three hours and 34 minutes after the time the identified medication should have been administered.

Interview with Registered staff member #112 identified that he/she did not do a shift count with the outgoing registered staff, he/she further explained that the identified Registered staff member's do the narcotic and controlled substance counts together as there is not enough time in the identified change of shift to count. This was confirmed with the resource nurse and the assistant director of care (ADOC). The Registered staff member further stated if counts were done with the identified shift at shift exchange then this error would have been picked up two days sooner.

Registered staff member #112 identified if a medication is wasted or destroyed if it was crushed they would put the medication into one of the plastic sleeves and place in the locked narcotic and or controlled substance box located in the cupboard in the medication room, this box was opened by the ADOC in the presence of the inspector there was no sleeve of medication found for the identified resident or any sleeve containing any crushed medications. He/she identified the ADOC or DOC have the key for this locked box. There is also a record called Drug Destruction and Disposal Monitored Substances, the record was reviewed, there was no entry made in regards to wasting the identified medication for the identified resident.

The ADOC followed through with the missing narcotic and was able to reach the

Registered staff member involved with the incident. Registered staff member #128 confirmed he/she did not follow the home's policy and have another registered staff co-sign the wasting of the narcotic but instead he/she threw it out in the garbage.

The ADOC and DOC confirmed that the home's policy for the destruction and documentation of narcotics and controlled substances was not followed by the registered staff and it is an expectation that all registered staff follow the home's policy for destruction of narcotics and controlled substances.

Policy group #3:
Medical Pharmacies manual, Monitored Medications, Individual Monitored Medication record, policy #6-5, dated February 2017, identifies the following: Each time a dose is administered the nurse is to sign the Individual Monitored Medication record and include date and time dose administered, amount given, amount wasted and new quantity remaining.

During the RQI and during the course of the medication inspection and observation of the narcotic and controlled substances, on an identified date, the inspector observed the narcotics and controlled substances blister packs to the Monitored Medication record for 7-Day Card with Registered staff member #112 the following was observed:

-an identified resident's Monitored Medication record for 7-Day Card was not signed as administered an identified medication and identified there were two tablets remaining. The medication pack contained one tablet. The eMAR confirmed one tablet of the identified medication was administered. SN #111 confirmed he/she did not sign the Monitored Medication record for 7-Day Card at the time he/she administered the medication to the resident.
-an identified resident, the record identified SN #111 did not sign the Monitored Medication record for 7-Day Card at the time he/she administered the medication.
-an identified resident's Monitored Medication record for 7-Day Card was not signed as administered the identified medication and identified there were one and half tablets remaining. The medication pack contained two half tablets. The eMAR confirmed one tablet of identified medication was administered. SN #111 confirmed he/she did not sign the Monitored Medication record for 7-Day Card at the time he/she administered the medication to resident #021.

Registered staff member #112 confirmed he/she did not check to see if SN #111 signed the Monitored Medication record for 7-Day Card at the time he/she

administered the medication to the three identified residents.

The DOC confirmed that it is the expectation that all registered staff and student nurses follow the home's policy and procedures and that they are required to sign all the medication records at the time they administer the medication to the resident.

Policy group #4:
Medical Pharmacies manual, The Medication System, The Medication Cart and Storage Maintenance, policy #3-5, date February 2017, identifies the following that the medication cart is maintained in good functional order and that the medication cart will be kept locked at all times except while in sight of a nurse.

During the RQI and during the course of the medication inspection, the inspector observed on an identified date, the medication cart on an identified home area was unlocked and the narcotic and controlled substance bin lid was not secured shut. The lid to this bin which contained the lock was locked but not shut completely in order to engage the lock into the box frame of the bin thus locking the lid and securing it.

Interview with SN #119 confirmed he/she knew the lid was not engaged and did not secure the box so that it was locked. He/she indicated that unless you dropped the lid from a height of three inches or higher the lid would not lock the narcotics and controlled substances bin. When asked what he/she should do about getting it repaired he/she replied they did not know.

Interview with Registered staff member when made aware of the problem with the narcotics and controlled substances bin immediately informed the inspector that the repair contact phone number was posted on the bottom of the eMAR screen and phoned the pharmacy and put in a repair order request.

Interview with the DOC confirmed that it is an expectation that all registered staff lock their medication carts and that he/she was not aware of any issues with the medication cart. The DOC confirmed the home failed to ensure that the drugs stored in the medication cart were secured and locked and indicated it is an expectation that when medication carts require repair that the registered staff contact the pharmacy to repair them.

Policy group #5:

Medical Pharmacies manual, The Medication Pass, policy #3-6, date February 2017, identifies the following: to conduct hand hygiene prior to and upon completion of administering medications.

Medical Pharmacies manual, Hand Hygiene, policy #3-16, date February 2017, identifies the following: perform hand hygiene before initial resident medication assistance or administration, and after contact with the resident.

During the RQI the inspector observed the administration of medication to an identified resident.

On an identified date, time and home area, the inspector observed SN #111 under the supervision of Registered staff member #112 prepare and administer medication to an identified resident. The SN was observed to remove the identified resident's medication from the medication pack into his/her hand and then placed the medication into the medication cup. During this process the SN #111 did not perform hand hygiene.

Interview with the DOC confirmed it is the expectation that registered staff perform hand hygiene throughout the administration process and that this was not acceptable. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) 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. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

During the RQI and during the course of the medication inspection, the inspector observed on an identified date, the medication carts on the following identified home areas were not locked and there were no registered staff present or within sight of the medication carts on three identified home areas. The inspector did observe visitors and residents within the area surrounding the medication cart.

On an identified home area with Registered staff member #123, an identified home area with Registered staff member #120 and an identified home area with Registered staff member #122 confirmed the medication carts were unlocked and unsupervised. The three staff all confirmed they knew the medication carts were to be locked when they were not in attendance.

Interview with the DOC confirmed that it is an expectation that all registered staff lock their medication carts when not in attendance of the cart. The DOC confirmed the home failed to ensure that the drugs stored in the medication cart were secured and locked. [s. 129. (1) (a) (ii)]

2. The licensee has failed to ensure that 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.

During the RQI and during the course of the medication inspection, the inspector observed on an identified date, the medication cart on an identified home area unlocked and upon further observation found the narcotic and controlled substance bin unlocked. There were no staff present at the time. The inspector did observe visitors and residents within the area of the medication cart.

Interview with SN #119 and Registered staff member #123 confirmed that the above noted medications were stored in the narcotic and controlled substance bin. Both confirmed that the medication cart and narcotic and controlled substance bin must be locked at all times when not in attendance.

The home's policies identify the following: Medical Pharmacies manual, The Medication System, The Medication Cart and Storage Maintenance, policy #3-5, date February 2017, identifies the following: that narcotics and controlled substances should be stored separately, double locked and in the dedicated box usually in the bottom drawer of the medication cart and that the medication cart will be kept locked at all times except while in sight of a nurse.

Medical Pharmacies manual, The Medication Pass, policy #3-6, date February 2017, identifies the following: to ensure the medication cart is locked when it is out of the registered staff site.

Interview with the DOC confirmed that the registered staff did not follow the home's policy and procedures and that it is the home's expectation that narcotic and controlled substance are to be secured and double locked at all times. [s. 129. (1) (b)]

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 stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #5: 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 has failed to ensure that every medication incident involving a resident and every adverse drug reaction is 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.

Record review of the following two incident reports revealed the following:

On an identified date, an identified resident's substituted decision maker (SDM) and physician were not notified of medication error where the resident received an additional amount of an identified medication.

On an identified date, an identified resident's SDM was not notified that his/her identified medication went missing.

An interview with the DOC confirmed that the above identified persons were not notified at the time of the medication incidents. He/she further confirmed it is an expectation that every medication incident involving a resident and every adverse drug reaction is reported to the resident or the resident's substitute decision-maker, the DOC, the MD, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. [s. 135. (1)]

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 every medication incident involving a resident and every adverse drug reaction is 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Record review completed by Inspector #647 of the Professional Advisory Committee meetings held on four identified meeting dates, revealed the Medical Director did not attend the meetings.

Interview with the DOC confirmed that the above identified staff did not participate in the quarterly meeting held on the above mentioned meeting dates to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. [s. 115. (1)]

Issued on this 19 day of January 2018 (A1)(Appeal/Dir# DR# 075)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge, 5e étage
TORONTO, ON, M2M-4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : PHILIP MOORMAN (Director) - (A1)(Appeal/Dir# DR# 075)

Inspection No. / No de l'inspection : 2017_491647_0019 (A1)(Appeal/Dir# DR# 075)

Appeal/Dir# / Appel/Dir#: DR# 075 (A1)

Log No. / No de registre : 025118-17 (A1)(Appeal/Dir# DR# 075)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Jan 19, 2018;(A1)(Appeal/Dir# DR# 075)

Licensee / Titulaire de permis : VICTORIA VILLAGE INC.
76 ROSS STREET, BARRIE, ON, L4N-1G3

LTC Home / Foyer de SLD : VICTORIA VILLAGE MANOR
78 ROSS STREET, BARRIE, ON, L4N-1G3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : OLIVIA SCHMITZ

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To VICTORIA VILLAGE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. The plan should include, but not be limited to ensuring the following:

1. Registered staff administer medications, in accordance to the College of Nurses of Ontario professional practice Standards and Guidelines:
a) The right client/resident,
b) The right medication/drug,
c) The right dose/amount,
d) The right route/method,
e) The right time,
f) The right reason,
g) The right site,
h) The right frequency.

2. All registered staff in the home receive education in the administering of medications as in accordance with the College of Nurses of Ontario professional practice Standards and Guidelines. The education must include a review of dosage calculations for all drugs.

3. Registered staff attendance of the education provided to be documented and maintained.

The plan shall be submitted to Jennifer.brown6@ontario.ca by December 19, 2017. The plan is to include the required tasks, the person(s) responsible for completing the tasks and the time lines for completion.

Grounds / Motifs :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the Resident Quality Inspection (RQI) and the inspection of handling of medication incidents and adverse drug reactions, inspector #557 reviewed the following medication incident report for resident an identified resident.

Review of the electronic medication administration record (eMAR) for an identified

date, indicated that the identified resident had been prescribed an identified medication and had been administered the identified medication on the date of the incident.

On the above mentioned identified date, a medication incident report was completed identifying the administration of identified medications to an identified resident that were not prescribed for the resident.

Record review of the identified resident's progress notes confirmed that he/she received another identified resident's drugs. A further record review indicated the home contacted poison control and the physician who suggested to transfer the identified resident to the hospital for medical assessment. The identified resident returned back to the home with a physician's order to resume all previously prescribed medications.

Review of the physician order's and the eMAR confirmed the identified resident did not have a physician order for the above identified drugs.

Interview with Registered staff member #104 confirmed he/she did administer the above identified drugs to the identified resident on an identified date. He/she further explained that it was a mistake and that particular day he/she was very busy and knows that he/she should go slower even if busy so that mistakes don't happen.

The home's policy in Medical Pharmacies manual, The Medication System, The Medication Pass, policy #3-6, dated February 2017, identified the following: to find the identified resident's eMAR and identify the medications the resident is to receive at the pass, to check each medication label against the eMAR for accuracy, and administer the medications.

Interview with the Director of Care (DOC) confirmed the identified resident received another resident's medication on an identified date. He/she met with Registered staff member #104 and reviewed the medication error with him/her and provided counseling. He/she further confirmed that the Registered staff member #104 completed a personal learning plan in regards to medication administration. The DOC confirmed it is the home's expectation that that no drug is administered to a resident in the home unless the drug has been prescribed for the resident by the registered staff. [s. 131. (1)] (557)

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

During the RQI, the home's medication and adverse drug reaction incident reports for an identified three month period, were reviewed.

On an identified date, a medication incident report was completed for an identified resident identifying the administration of a medication. The identified resident was to receive an identified dose of medication however, he/she received more medication than the prescribed dose.

During the course of the inspection the inspector was unable to reach the identified Registered staff member #140, who was involved in the above identified incident.

Review of the homes investigation notes and an interview with the DOC confirmed he/she spoke with the identified Registered staff member and reviewed the medication error with him/her. The Registered staff member's explanation was that he/she completed an assessment of resident and that he/she administered the incorrect amount of identified medication.

The DOC confirmed it is the home's expectation that medications are administered as prescribed to all residents with in the home and that identified resident did receive the incorrect amount of an identified medication.

A compliance order will be served to the home based on the scope, which is a pattern, the severity of the non-compliance was minimal harm and or potential harm and or risk, and the home had previously been issued a voluntary plan of correction (VPC) as part of inspection 2016_535557_0017 on December 13, 2016, for this legislation. [s. 131. (2)] (557)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Dec 31, 2017

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

(A1)(Appeal/Dir# DR# 075)
The following Order has been rescinded:

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,

(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;

(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or

(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19 day of January 2018 (A1)(Appeal/Dir# DR# 075)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHILIP MOORMAN (Director) - (A1)(Appeal/Dir# DR# 075)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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Service Area Office / Bureau régional de services : Toronto