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

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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
Nov 26, 2019	2019_565647_0028	020916-19	Complaint

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

JENNIFER BROWN (647)

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): November 19 - 22, 2019

The following intake was completed in this Complaint inspection:
-one log was related to a complaint submitted to the Director regarding care concerns, staffing, falls with injury, home area change, and dietary.

Follow up inspection #2019_565647_0029 and Critical Incident System inspection #2019_565647_0030 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Associate Director of Care (ADOC), Director of Dietary, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and substitute decision makers (SDM).

During the course of the inspection, the Inspector(s) also conducted a daily tour of the resident care areas, observed staff to resident interactions and the provisions of care, reviewed internal documents, and policies and procedures.

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

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

A complaint was submitted to the Director, which indicated that after resident #002's fall, their medication was not provided as prescribed.

Inspector #647 reviewed a Physician's order, that indicated resident #002 was to receive an identified medication for a specific time period.

A review of resident #002's health record, indicated that the rationale for the administration duration of this medication was due to an identified medical diagnosis which was contraindicated due to the medication side affects that may impact resident #002's overall health condition.

Inspector #647 reviewed the electronic medication administration record (eMAR) for resident #002 which indicated that the resident received the identified medication as prescribed. A further review of the eMAR, indicated that the resident continued to receive this medication after the prescribed duration had ended. The eMAR indicated that resident #002 received three additional doses of the medication.

During an interview with Registered Practical Nurse (RPN) #106, they indicated that they were the one that had transcribed this Physician's order, however did not enter the specific administration duration on the eMAR.

Inspector #647 interviewed the Director of Care (DOC) who stated that the nursing staff who administered the identified medication after the specific administration duration had not seen the "end date" in the eMAR. The DOC further indicated that resident #002 continued to receive the identified medication for three additional doses which were not prescribed. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Please refer to WN #1 for complaint and medication information.

A review of resident #002's health record, indicated that the rationale for the administration duration of this identified medication was due to an identified medical diagnosis which was contraindicated due to the medication side affects that may impact resident #002's overall health condition. The Physician's order further indicated that during the three day administration of the identified medication, staff were to assess the resident for specific indicators every one to two hours when using the medication.

Inspector #647 reviewed the eMAR for resident #002 which indicated that the resident received the identified medication on eight occasions.

A review of the health record that included the eMAR notes and the progress notes indicated that staff had not assessed or documented that they monitored the resident for the specific indicators when the resident was administered the medication.

During an interview with RPN #106, they indicated that they were the one that had transcribed this Physician's order, however did not see the instructions to assess the resident.

During an interview with the Associate Director of Care (ADOC), they indicated that there was no evidence to indicate that the resident was assessed for the specific indicators. They further indicated that staff had missed that section of the Physician's order. [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

Issued on this 26th day of November, 2019

[redacted]

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

Original report signed by the inspector.