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 soins 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
May 9, 2017	2017_542511_0008	030784-16	Complaint

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF HALTON
1151 BRONTE ROAD OAKVILLE ON L6M 3L1

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

CREEK WAY VILLAGE
5200 Corporate Drive BURLINGTON ON L7L 7G7

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

ROBIN MACKIE (511)

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): March 31, April 4, 5, 7 10, 19, 2017.

Complaint #030784-16 related to the resident plan of care was inspected.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Manager of Resident Care (MORC/days), Manager of Resident Care (MORC/evenings), MDS-RAI co-ordinator, Staff Educator, Registered Practical Nurse (RPN), Registered Nurse (RN), housekeeping staff and identified family members.

The Inspector observed resident care, reviewed clinical records and reviewed applicable home policies, practices and medical directives.

The following Inspection Protocols were used during this inspection:
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. 81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

Findings/Faits saillants :

1. The Licensee failed to ensure that no medical directive or order was used with respect to a resident unless it was individualized to the resident's condition and needs.

A complaint was received from the family of resident #001 that indicated a home's

medical directive had not been individualized to meet the needs of their family member. During an interview, the family member alleged the home had not tested or treated the resident for an identified condition because the resident's signs and symptoms had not meet the criteria as outlined in the home's medical directive for the condition. The resident was documented to have a long identified history of this identified condition on admission to the long term care home and had been receiving supplements as a preventative measure.

On a specific date in 2016, a registered staff documented the family member requested to have a test performed because the family stated there was a change in the resident's behaviour. The family member stated they told the staff that the resident had demonstrated similar behaviours, when they were treated previously, for this identified condition. The staff documented the resident's change in behaviour but stated the signs and symptoms of the identified condition were not present, as outlined in the medical directive. There was no evidence the test was completed. The following day the resident's condition continued to change and they were sent to hospital by the RN on duty.

A review of the hospital report, for the resident's hospitalization, indicated the resident had been diagnosed and treated for the presumed identified condition. The resident returned to the home with a prescription for the identified condition.

Interview with Registered Practical Nurse (RPN) #105 stated they referred to the medical directive for the identified condition and an algorithm, that was laminated on the floor, to follow for all residents. RPN #105 confirmed the medical directives were not individualized to the needs of resident #001. RPN #105 stated that once a medical directive was initiated it should have been wrote in the physician's orders as a medical directive and would have been transferred over to the Electronic medication administration record (eMAR) and/or the Electronic treatment administration record (eTAR) and was not.

A review of the home's medical directives policy identified a medical directive as a "prescription for a treatment or procedure that may be performed by a professional other than a physician for a range of patients who meet certain conditions". The home's medical directives further described the accountability for implementing the medical directives by both the physician and the nurses.

Interview with RN #102 confirmed that the home had not always tested or provided

treatment for the identified condition and that the home was following a standard/general medical directive that had not been individualized to each resident. After a multidisciplinary meeting with the family member, the home created an individual plan of action for resident #001's identified condition.

Interview with the RN, Manager of Resident Care (MORC) confirmed resident #001, #002 and #003 had a history of the identified condition and followed the same generalized directive without being individualized, either through the eMAR/eTAR , to the specific needs and conditions of each resident. The MORC confirmed the licensee had failed to ensure that no medical directives or order be used with respect to a resident unless it was individualized to the resident condition and needs. [s. 81.]

Issued on this 18th day of May, 2017

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

Original report signed by the inspector.