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

Division de la responsabilisation et de la performance du système de santé
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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 5, 2014	2014_303563_0026	L-001013-14	Resident Quality Inspection

Licensee/Titulaire de permis

RITZ LUTHERAN VILLA
R.R. 5, MITCHELL, ON, N0K-1N0

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

RITZ LUTHERAN VILLA
PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0

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

MELANIE NORTHEY (563), DONNA TIERNEY (569), INA REYNOLDS (524), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 18 - 22 and August 26-27, 2014

Concurrent inspections include: L-001017-14 and 000594-14

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Acting Director of Care, the Dietary Manager, the Building Service Director, the Scheduling Clerk, the Registered Dietitian, the Cook, three Dietary Aides, the Campus Life Enrichment Director, the Resident Assessment Instrument Coordinator (RAI-C), two Registered Nurses, three Registered Practical Nurses, nine Personal Support Workers (PSW), three family members, and forty-one residents.

During the course of the inspection, the inspector(s) conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

Observations of the first floor medication cart on August 19 and 26, 2014 revealed empty medication strip packages with resident names and medication names printed on them in the regular garbage collection container with other garbage.

The home's policy #3-6 The Medication Pass indicates: "14. Empty strip pouches can be destroyed with water to removed information and placed into the garbage or shredded."

Staff interview with a Registered Practical Nurse (RPN) revealed they discard the empty strip packages with resident names and medication names on them in the regular garbage without removing the personal health information. The RPN confirmed that Resident personal health information is at risk when discarding the empty strip packages without removing the resident names and medication names.

Staff interview with the Acting Director of Care (DOC) revealed staff are expected to remove the resident names from the empty strip packages with water before discarding them in the regular garbage. The Acting DOC confirmed that Resident personal health information is at risk when discarding the empty strip packages without removing the resident names and medication names. [s. 3. (1) 11. iv.]

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 Resident have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Observation of Resident # 76 bed system revealed rails are used. Interview with Resident # 76 revealed staff physically assist the resident while in bed.

Record review of the Minimum Data Set (MDS) revealed Resident # 76 requires the assistance of staff for bed mobility.

Record review of the care plan revealed the care plan did not have bed mobility goals and interventions to direct care.

Staff interview with the RAI-C confirmed Resident #76 does use bed rails to assist resident with bed mobility, confirmed resident requires assistance for bed mobility with staff assistance and confirmed the care plan and kardex is absent of interventions related to bed mobility.

2. Record review of the Minimum Data Set (MDS) revealed Resident # 79 Communication Resident Assessment Profile (RAP) stated, "Current care plan interventions will continue."

Record review of the care plan revealed the care plan did not have communication goals and interventions to address resident's communication difficulty as identified in the MDS Assessment dated June 26, 2014.

Staff interview with the Resident Assessment Instrument Coordinator (RAI-C) confirmed Resident # 79 has a communication problem and confirmed there are no

interventions in place to address the resident's communication deficit as identified in the MDS.

3. Record review of Resident # 35 most recent Minimum Data Set (MDS) assessment revealed that a change in the resident's cognitive decline had a negative effect on his/her communication and that "current care plan interventions will continue.”

Documentation review and interview with the Acting Director of Care confirmed that the current plan of care for Resident #35 did not indicate goals or interventions related to the communication assessment. The Acting Director of Care shared that it is an expectation that the written plan of care sets out the planned care for the resident as it relates to communication.

4. Observation of Resident # 35 bed system revealed bed rails are used.

Record review of the Minimum Data Set (MDS) revealed resident # 35 requires physical assistance of staff for bed mobility.

Record review of the care plan revealed the care plan did not have bed mobility goals and interventions to direct care.

Staff interview with the RAI-Coordinator confirmed Resident # 35 does use bed rails to assist resident with bed mobility, confirmed the resident requires assistance for bed mobility with staff assistance and confirmed the care plan and kardex is absent of interventions related to bed mobility.

5. Record review for Resident # 4 revealed the Point of Care (POC) documentation related to bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed) indicated extensive to total assistance over 7 days.

Record review of Resident # 4’s plan of care revealed there was no direction to staff regarding assistance required for bed mobility.

Staff interview with a Registered Practical Nurse revealed there should be directions to staff related to assistance required for bed mobility for all residents requiring assistance with bed mobility and that the home has not included bed mobility in care plans for any residents as applicable. [s. 6. (1) (a)]

6. The licensee has failed to ensure that the written plan of care provides clear direction to staff and others who provide direct care to the resident.

Record review of Resident # 35 care plan identified the resident as being at risk for falls where by a purple star has been placed above the bed on the wall and on the resident's wheelchair and walker to alert staff that the resident is at risk.

Resident room observation revealed that there was no purple star placed above the bed on the wall as stated in resident's care plan.

Confirmation of this observation was obtained by the Acting Director of Care and the RAI-Coordinator and they confirmed it is the home's expectation that a purple star be posted on the wall over the resident's bed as stated in the care plan. [s. 6. (1) (c)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and to ensure that the written plan of care provides clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

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 the "5-5 Self-Administration of Medications" policy put in place is complied with.

a) The home’s policy # 5-5 Self-Administration of Medications indicates: “1. Prescriber and nursing team assesses resident for their capacity to self-administer their own medication and complete “Self-Administration Assessment Form”. File form with MAR. 2. Prescriber writes the medication order including in the directions “may self-administer”. 5. Prescriber and/or nurse counsels the resident regarding name of medication, strength, dosage, frequency, indication(s), method of use, adverse effects, safe storage, possible effects and reordering procedure. The resident must understand the need for self-monitoring and documentation of the use of the drug. Prescriber or nurse document counseling of all of the above in the progress notes or facility specific document. 6. Resident signs “Resident Self-Administration of Medication Agreement” and files signed form in resident’s chart. 8. Complete “Self-Administration Assessment Form” quarterly or with any change in resident’s status. 9. Document in resident’s care plan that they have been identified as capable of self-administering medications. 10. Monitor the resident’s compliance in the use of the self-medication. If an indication of misuse is noted, the resident will be further counseled or the medication removed. 12. Document in progress notes weekly that monitoring has been done and the extent which the resident is compliant with self-administration. Report any concerns to the physician."

b) Record review for identified residents revealed no Self-Administration Assessment form completed, no documentation of counseling regarding self-administration, no Resident Self-Administration of Medication Agreement completed, nothing noted in the plans of care regarding self-administration of medication, no evidence of monitoring of medication use and no progress notes regarding self-administration for either resident.

c) Staff interview with two Registered Practical Nurses and record review of physician’s orders revealed there is no physician’s order to self-administer medications.

d) Staff interview with two Registered Practical Nurses revealed self-administration of a medication is not monitored, there is no system in place to monitor or document the number of tablets used, the number of tablets remaining, the expiry dates, the frequency or time of use. They confirmed that other residents and unregulated care providers have access to this controlled medication and that this poses a risk to

residents and the home.

e) Staff interview with the Director of Care and the Administrator revealed there is risk for residents who self administer medication and that the policy for self-administration should be followed with monitoring of use completed and documented.

The licensee has failed to ensure that the "5-1 Expiry and Dating of Medications" policy put in place is complied with.

a) The home’s policy # 5-1 Expiry and Dating of Medications indicates: “1. Examine the expiry dates of all medications on a regular basis. Be especially careful to check all storage areas for extra medication, PRN medications, Government stock, monitored medication (narcotic and controlled), topicals and eye drops. #2. Remove any expired medications from stock and order replacement if necessary.”

b) A partially full open bottle of stock ASA 325mg with an expiry date of June 2014 was found in the first floor medication cart.

c) Staff interview with a Registered Practical Nurse revealed this bottle of ASA should not be in the medication cart.

d) Staff interview with the Acting Director of Care confirmed and record review revealed the "Nurse Manager Job Routine Night Shift" form directs the night Registered Nurse to “Check supplies in the drug room, treatment room, medication and treatment carts and nursing storage room and ensure shelves are organized, as well as check for any expired stock (excluding government stock) and place into the medication destruction container to be destroyed on Friday nights. Government stock that has expired needs to be put into a separate box in the drug room labeled “Government stock” as it has to be sent back”. [s. 8. (1)]

2. The licensee has failed to ensure that the "Snack Cart Procedure (to compliment Extendicare Policy Resi-05-02-03 Resident Care)" put in place is complied with.

a) Record review of the "Snack Cart Procedure (to compliment Extendicare Policy Resi-05-02-03 Resident Care)" revealed a system for delivery and return of nourishment carts that includes the secured storage of the snack cart when not in use and staffing direction so that the cart is never unattended and accessible to residents.

b) Staff interview with the Administrator revealed a new snack delivery process was hand delivered to all nursing and dietary staff in both Mitchell homes. The new snack cart procedure was in effect immediately where by dietary staff delivers the cart to the nursing units and locks the cart in the nursing station where residents can not access it while unattended, snack delivery is done with 2 staff, one staff staying with the snack cart at all times.

c) Observation of snack delivery by inspector # 524 and # 563 on August 21, 2014 between 1510 - 1530 hrs. revealed a Personal Support Worker (PSW) left the snack cart unattended and accessible to residents in the west hallway on first floor. Snack cart had fluids and cookies on the cart for distribution.

d) Interview with PSW confirmed that if PSW staff are busy and only one staff member is available to deliver the snacks, then the cart must be taken into the resident's room and never left unattended.

e) Interview with the Administrator confirmed it is the home's expectation that "Snack Cart Procedure (to compliment Extendicare Policy Resi-05-02-03 Resident Care) is followed where by the snack cart not be accessible to residents and never out of sight of staff when in use. [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 ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a good state of repair.

Observation of resident home areas during a tour on August 18, 2014 revealed:
- Numerous hallway walls, doors and door frames were damaged and paint chipped,
- Feeding stool cushion on second floor dining room was ripped with exposed sponge, and
- a plastic guard on the door frame that was gouged with sharp edges.

Observation of multiple resident bathrooms on August 18, 2014 revealed numerous holes in bathroom walls where towel bars and/or toilet paper holders were previously placed. The holes were not filled or repaired.

Observation of multiple resident rooms on August 18 and 19, 2014 revealed numerous bedroom walls, door frames and doors were scraped and chipped and in need of paint.

Interview with the Building Service Director August 21, 2014 confirmed the need for repairs and that repairs have been initiated. [s. 15. (2) (c)]

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 the home, furnishings and equipment are maintained in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by Residents, staff and visitors at all times.

Observation of Resident # 52 revealed the resident was verbally calling staff for assistance and call bell was not within reach. Resident # 52 was sitting beside the bed and the call bell was on the floor under the bed. When asked if he/she could reach the call bell the resident indicated that he/she could not reach it. Resident # 52 then demonstrated that they knew how to use the call bell when it was placed in their hands. This was confirmed by the Personal Support Worker.

Observation of Resident # 52 on another day revealed the resident was verbally calling staff for help and the call bell was not within reach. This was confirmed by the Registered Nurse.

The Registered Nurse shared that it is the home's expectation that resident call bells are to be within the residents reach when in their room. Call bells can be clipped to resident's clothing while in wheelchair or placed in the resident's hand. [s. 17. (1) (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 the resident-staff communication and response system can be easily seen, accessed and used by Residents, staff and visitors at all times, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Residents' Council concerns are responded to in writing within 10 days of receiving the concern.

A review of the Ritz Lutheran Villa Resident Food Committee meeting minutes of April 3, 2014 and interview with Resident #76 revealed residents raised a concern "that snacks are coming too late" and "snack times are not being followed."

Staff interview with the Dietary Manager on August 27, 2014 confirmed no response to residents was provided related to snack time concerns. Staff interview with the Administrator confirmed that the home did not respond in writing within 10 days to the snack time concerns raised by the Resident Food Committee. [s. 57. (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 the Residents' Council concerns are responded to in writing within 10 days of receiving the concern, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that food and fluids were served at a temperature that was both safe and palatable to the residents.

It was identified in resident interviews that the vegetables "aren't always hot". Observation of the lunch meal service on August 20, 2014 on first floor dining room revealed the following menu items were not being held at palatable temperatures when probed at 1255 hours:
- Broccoli Florets 120F
- Cocktail Vegetable Medley 130F

Review of "Point of Service Food Temperatures" policy DIET-07-01-03 dated June 2013 revealed the acceptable minimum for hot food temperature served to residents is 140F. The resident food committee meeting minutes indicated that residents have raised concerns regarding food temperatures not always hot enough if they are one of the last tables served, dating back to June 2014.

During interview with the Dietary Manager on August 20, 2014, she confirmed her expectation that staff maintain food temperatures of menu items during the lunch meal service. [s. 73. (1) 6.]

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 food and fluids were served at a temperature that was both safe and palatable to the residents, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission.

Review of the immunization records on August 27, 2014 for three randomly selected residents revealed:

Resident # 56 admission with no evidence of TB testing done by the home to date or 90 days prior to admission.

Resident # 57 admission with TB Mantoux skin test step 1 and 2 completed after the 14 days of admission.

Resident # 59 admission with no evidence of TB testing done by the home to date or 90 days prior to admission.

Interview with registered staff confirmed that tuberculosis screening has not been completed since admission or 90 days prior to admission for Resident # 56 and # 59 and tuberculosis screening was not completed within 14 days of admission for Resident # 57. [s. 229. (10) 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 each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs.

Record review of physician's orders revealed:
Resident #3 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes
Resident #4 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes
Reisdent #5 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes and has a medical directive order for Nitroglycerine and does not have a diagnosis related to a cardiac disorder
Resident #6 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes and has a medical directive order for Nitroglycerine and does not have a diagnosis related to a cardiac disorder
Resident #7 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes and has a medical directive order for Nitroglycerine and does not have a diagnosis related to a cardiac disorder
Resident #9 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes
Resident #35 - has a medical directive order for Glucagon and does not have a diagnosis related to diabetes

Staff interview with the Acting Director of Care (DOC) and a Registered Nurse (RN) revealed the new Medical Director has recently changed the medical directives ordering process using a new form for physician's to order medical directives individualized to the residents' needs. Previously all available medical directives were ordered for residents. The Acting DOC confirmed that the physicians are in the process of individualizing medical directives for residents, completing a few every week, however, this has not been completed for all residents in the home yet. The Acting DOC and the RN confirmed there is risk to residents who have medical directives ordered that are not individualized to their needs. [s. 117. (b)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_232112_0038	563
LTCHA, 2007 S.O. 2007, c.8 s. 76. (6)	CO #002	2014_232112_0038	563

Issued on this 5th day of September, 2014

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