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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 11, 2016	2016_178624_0015	006472-16, 011272-16, 009857-16	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

BALLYCLIFFE LODGE NURSING HOME
70 STATION STREET AJAX ON L1S 1R9

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

BAIYE OROCK (624)

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): June 20, 21, 22, 24, 27, 28 and 29 of 2016

The following logs were inspected: Log # 011272-16 (anonymous complaint about mould in the home), Log # 006472-16 (related to numerous falls of resident #011) and Log # 009857-16 (related to medication and nutritional concerns). Evidence of non-compliance found in this inspection under LTCHA, 2007, section 6. (7), related to log # 006472-16 will be identified in Inspection report #2016_293554_0013 which was carried out concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), a Corporate Nursing Consultant, the Environmental Service Manager, the Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, and Maintenance personnel. A tour of the building was completed and documentation review was also completed for relevant policies and procedures related to falls, medication, and nutrition and hydration.Maintenance logs for repairs completed in the home was also reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Falls Prevention
Medication
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that when the nutritional care needs of resident # 010 had changed, the resident's plan of care was reviewed and revised to reflect the changes.

Related to log # 009857-16,

Resident # 010 was admitted into the Home on a specified date and time. Upon admission, the resident was alert, eating and drinking adequately. According to the resident health records, eighteen days after admission into the home, the resident was put on a psychotropic medication, sent to hospital two days later for aggressive behavior towards staff and upon return to the Home, the medication dose was increased. Between the eight day period when the resident was on the medication, the resident health records indicated that the resident was mostly drowsy and refused eating.
The resident's food and fluid intake dropped significantly during the identified eight day period. A review of resident # 010's health records indicated that when the resident's nutritional intake had dropped significantly, the nutritional needs were not reassessed and the resident's care plan was not reviewed and revised with any new interventions to deal with the poor nutritional intake.

In an interview with PSWs #113 and #123, both reported that when they noticed that a resident's intake is low compared to the resident's norms, they report immediately to the RPN who in turn makes a referral to the dietitian for assessment of the resident.
Interviews with RPNs #105 and 109, both charge nurses, they stated to the Inspector that the Home's expectation is to refer a resident to the Registered Dietitian (RD) when the resident's fluid intake is less than 8 servings per day for three consecutive days. Both RPNs were not aware of any interventions that were in place to improve resident #010's food and fluid intake between the identified eight day period. The RD, upon review of the intake records, reported that a referral was not received until six days after the medication was initially prescribed and after resident's POA had requested a change in the resident's diet. The RD further stated that the resident was not assessed and no new interventions were put in place since the resident was hospitalized when the referral was received.

In an interview with the DOC, with a Corporate Nursing Consultant present at the interview, they both confirmed that the Home's expectation is to complete a referral to the RD if a resident's intake is less than 8 servings per day for three consecutive days. The

Corporate Nursing Consultant insisted that because the resident was sent to hospital two days after the medication was initially prescribed (returned the very next day), six days later (and returned the same day) and then two days later (returned after two weeks), the resident did not spend any three consecutive days in the home and as such did not need an RD referral, despite one been completed for a different reason. On new interventions that were put in place to improve the resident's food and fluid intake during the the identified eight day period, the Corporate Nursing Consultant insisted the health care team had considered an intervention which was not implement due to resident's behaviors and also that resident was been spoon fed during the identified period, despite no other interviewed staff member indicating this was the case.

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 whenever a resident's care needs have changed with regards to food and fluid intake, the resident is reassessed and the plan of care reviewed and revised to reflect the changes, 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 failed to ensure that when resident # 010 was put on psychotropic medication, that there was monitoring and documentation of resident #010's response to the medication and the effectiveness of the medication.

Related to log # 009857-16,

Resident # 010 was admitted into the Home on a specified date and time. Upon admission, the resident was alert, eating and drinking adequately. According to the resident health records, eighteen days after admission into the home, the resident was put on a psychotropic medication, sent to hospital two days later for aggressive behavior towards staff and upon return to the Home, the medication dose was increased. Between the eight day period when the resident was on the medication, the resident health records indicated that the resident was mostly drowsy, refused eating and was hospitalized twice. A review of the resident's health records between the identified eight day period revealed no documentation indicating the monitoring and documentation of resident's response to, and the effectiveness of, the medication.

In an interview with RPN #122 (who had worked on the day the medication was started), the RPN stated that the expectation of the Home is that when a resident is put on a psychotropic medication, there will be a progress note entry each shift to document the effectiveness of the medication and the resident`s response to the medication. The RPN reported not being sure why there was no documentation related to the medication on the identified date. RPN # 109, who worked as charge nurse on resident 010's home area during the identified period, also confirmed the expectation of documenting the effectiveness of the medication and the resident response to the medication in the progress notes.

When the DOC was asked about the Home's expectation regarding residents on psychotropic medication, she stated that after administration of medication, the resident's response to the medication is to be documented in Point Click Care (PCC, i.e progress notes). The DOC then requested to verify the progress notes and get back to Inspector. Later, a Corporate Nursing Consultant who was present at the interview with the DOC, brought progress notes entry that were specific to 1:1 monitoring of resident's behaviors and insisted they were indicative that resident's response to the medication were being monitored, even though the notes had no reference to the medication, the resident's response to the medication or the effectiveness or impact of the medication on the

resident

Issued on this 11th day of July, 2016

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

Original report signed by the inspector.