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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 20, 2017	2017_538144_0042	022837-17	Resident Quality Inspection

Licensee/Titulaire de permis

1230839 ONTARIO LIMITED
708 WELLINGTON STREET WALLACEBURG ON N8A 2Y6

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

BROUILLETTE MANOR
11900 BROUILLETTE COURT TECUMSEH ON N8N 4X8

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

CAROLEE MILLINER (144), ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 6, 2017.

The following intake was completed within the RQI:
030103-16, IL-47218-LO - Complaint related to the plan of care, dining and snack service, falls prevention and management, duty to protect, nursing and personal support services and resident rights.

During the course of the inspection, the inspector(s) spoke with 20+ residents, three family members, one Residents' Council Representative, one Family Council Representative, the Administrator, Director of Care, Registered Dietician, Activity Director, two Registered Nurses, four Registered Practical Nurses, three Personal Support Workers, three Health Care Aides and one Housekeeping Aide.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessments, reassessments and monitoring, including the resident's response, was documented.

During stage one of the Resident Quality Inspection (RQI), Inspector 590 observed a specific resident with a restraint device in place.

Review of the current care plan showed that their use of the device was part of the care plan.

Review of the home's restraint documentation record showed that there were designated areas for Personal Service Workers (PSW's) to document required observations of the resident when the restraint device was in place and their initials. There was also a section for registered staff stating their initials were required confirming completeness of PSW documentation and the observations registered staff were also required to complete.

Review of the home's policy titled Minimizing Restraining of Resident and the Use of Personal Assistance Service Devices (PASD's), last revised in December 2011, stated the following in the "Monitor and Evaluate" section:

Individual Residents:
"Registered staff are to re-assess need for restraint and if it can be minimized Q8H"
"Flow sheet documented Q1H"

In the Documentation and Parties Responsible section there was a chart that states RN, RPN, Personal Support Worker are responsible to complete the "Restraint Flow Sheet: frequency hourly".

A dated memo authored by the Director of Care (DOC) and addressed to nursing personnel was reviewed by Inspector 144. The memo included a statement that restraint documentation was often incomplete and that restraints must be signed for according to policy. During the RQI, the DOC told Inspector 144 that restraint documentation by nursing staff continued to be a concern.

Two PSW's shared that PSW staff were responsible for completing the hourly restraint checks and recording their findings on the Restraint Check record.

One Registered Nurse (RN) shared that PSW's were responsible for completing the hourly restraint checks and recording their findings on the Restraint Check record. The RN further shared that the registered staff were required to sign the Restraint Check record at the end of each shift which indicated that the documentation had been completed and that the resident was safe.

Review of the above residents' clinical record for one identified month in 2017, showed that on twenty-occasions, the required restraint checks record was not completed by RN's and PSW staff.

Three PSW's shared that the reason Restraint Check documentation was not completed was that sometimes there was not enough time during their shift to document and that the residents were monitored and cared for.

The Administrator and DOC shared that the home's expectation was that Restraint Check records would be completed each shift by the PSW's and registered staff.
Inspector 590, the Administrator and DOC reviewed the Restraint Check records together. The Administrator and DOC agreed that the required documentation had not been completed as expected. [s. 110. (7) 6.]

2. During stage one of the RQI, Inspector 590 observed a second resident with a restraint device in place.

The second resident's current care plan on review showed that the device was part of the care plan.

Two PSW's shared that the PSW staff were responsible for completing the hourly restraint checks and documenting the checks on the Restraint Check record.

One RN shared that PSW's were responsible for completing the hourly restraint checks and documenting them on the Restraint Check record. The RN further shared that the registered staff were required to sign the Restraint Check record at the end of each shift to acknowledge that the documentation had been completed and that the resident was safe.

Review of the second resident's restraint flow record for one identified month in 2017, showed that on twenty-five occasions, the required restraint checks record was not completed by RN's and PSW staff.

Three PSW's shared that the Restraint Check documentation was not being completed as sometimes there was not enough time during their shift to document and that the resident's were monitored and cared for.

The Administrator and DOC shared that the home's expectation was that Restraint Check records were completed each shift by the PSW's and registered staff. Inspector 590, the Administrator and DOC reviewed the Restraint Check records together. The Administrator and DOC acknowledged that documentation had not been completed as expected.

The severity of this issue was determined to be a level one as there was minimal risk. The scope was widespread during the course of this inspection. There was no history of related non-compliance with this section of the regulations. [s. 110. (7) 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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that all assessments, reassessments and monitoring, including the resident's response, is documented, to be implemented voluntarily.

WN #2: 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 controlled substances were 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, Inspector 590 observed controlled substances scheduled for destruction stored in a non-stationary locked box in a locked cupboard in the hairdressing room of the home.

Inspector 144 inquired with the Administrator about the storage of the controlled substances and shared that the Administrator acknowledged that the controlled substances should be kept in a stationary and double locked area of the home.

The severity of this issue was determined to be a level one as there was minimal risk.
The scope was isolated during the course of the inspection.
There was no history of related non-compliance with this section of the regulations. [s. 129. (1) (b)]

WN #3: 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 was 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.

Review of one identified Medication Incident Report involving one resident showed that the section confirming the incident was reported to the resident/Power of Attorney (POA) and the Pharmacy was not completed.

Review of a second identified Medication Incident Report involving a second resident showed that the section confirming the incident was reported to the resident/POA was not completed.

Review of resident progress notes for both identified residents showed that on and after the dates of the incidents, there was no documentation of the incidents being reported to either the resident or their POA's, if applicable.

The home's policy titled Reporting Medication Incidents, policy number 7.3, last revised July 2014, included the Medication Incident Report and the instructions for completion. The Medication Incident Report included "Instructions for Completion" and identified the following areas needed to be completed: the Home name, date and time of incident, resident name, time incident was discovered and who it was reported to.

One RPN and one RN shared that the RN's were responsible for notifying the resident/POA about medication incidents.

The DOC shared that if the area on the Medication Incident Report was not checked off for resident/POA and Pharmacy notification, it would indicate that they had not been notified. The DOC also shared that the RN's were responsible for notifying the Pharmacy of medication incidents and was sure that the form had been sent to Pharmacy, though the incident report showed that the Pharmacy had not been notified.

The DOC said that it was part of the home's process to notify resident's/POA's of all medication incidents and that she could not confirm that the identified resident's/POA's had been notified of the medication incidents.

The severity of this issue was determined to be a level one with minimal risk. The scope of this was a pattern during the course of the inspection.
There was no history of related non-compliance with this section of the regulations. [s. 135. (1)]

Issued on this 21st day of November, 2017

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

Original report signed by the inspector.