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 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 26, 2018	2018_580568_0015	033231-16, 024152-17, 028615-17, 028619-17, 028809-17, 001237-18, 003569-18, 009791-18, 016914-18	Critical Incident System

Licensee/Titulaire de permis

Corporation of the County of Bruce
41 McGivern Street P.O. Box 1600 WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

DOROTHY GINTHER (568), JANETM EVANS (659)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, 31, 2018; September 4, 5, 6, 7, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 24, 25, 2018

The following intakes were intakes were completed during this Critical Incident System Inspection:

Log #033231-16, CIS #M507-000027-16 related to medication;
Log #028615-17, CIS #M507-000024-17; log #028619-17, CIS #M507-000025-17; log #028809-17, M507-000027-17 related to hospitalization and change in condition;
Log #001237-18, CIS #M507-000001-18; log #016914-18, CIS #M507-000026-18; log #009791-18, CIS #M507-000016-18; log #024152-17, CIS #M507-000015-17 in relation to falls resulting in injury;
Log #003569-18, CIS #M507-000005-18 in relation to multiple care concerns.

Please Note: A Written Notification and Compliance order related to LTCHA, 2007, c.8, s. 6. (7), (1) (b) plan of care; O. Reg 79/10, s. 50. (2) (a) (i) (ii) skin and wound assessments; O. Reg 79/10, s. 31 (3) sufficient staffing was identified in this inspection and has been issued in Inspection Report 2018_580568_0014, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Director of Health Services, Administrator, Director of Care, Administrative Assistant, RAI Coordinator, Dietary Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, residents and families.

The inspectors also observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, staff schedules, medication incidents; observed the provision of resident care, and resident-staff interactions.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.

- **3 WN(s)**
- **3 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. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

a) The home's Falls Prevention and Management Program, revised March 1, 2015, under section b. Fall and Post Fall Assessment and Management stated "Initiate Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury. Monitor every hour for the first 4 hours and then every 4 hours for 24 hours post fall for signs of neurological changes (eg. facial droop, behaviour changes, and weakness on one side)."

i) Review of a resident's clinical record identified that the resident sustained two unwitnessed falls on a specified date. A head to toe assessment was performed and there were no apparent injuries after each of the falls. There was no documentation in terms of follow-up including a head injury routine for either of the falls.

During an interview with a Registered Practical Nurse (RPN) they said that when a fall is not witnessed or if it was witnessed and there was potential head trauma then a head injury monitoring tool would be initiated. This would involve monitoring the resident's neurological signs and symptoms for a period of 48 hours.

The Director of Care (DOC) said they were not able to find documentation that head injury routines were completed for the identified resident's two falls.

ii) An identified resident was assessed as a high risk for falls.

Review of the clinical record for the resident showed they had a number of falls over a

three month period. Risk management documentation was completed as the post fall assessment in each instance.

Review of the neurological records related to the falls showed three records completed - one for an illegible date, one for two specified dates. Instructions documented on this record stated "Head injury with/without loss of consciousness to have assessments hourly for four hours, then reduce to every eight hours for 48 hours if no abnormalities noted". Review of the records showed the instructions on the document were not being followed related to the timeline for completing the checks, and for one of the falls it was documented at two checks "sleeping" instead of rousing the resident.

The RPN said if a fall was not witnessed or the fall was witnessed and there was head trauma they would start a head injury monitoring tool. The resident would be monitored for six shifts if there was an injury or three shifts if there was no injury.

The Registered Nurse (RN) stated a head injury routine was completed for unwitnessed falls every hour for four hours then every shift for the next six shifts. They said that reminders were entered into the planner for staff to follow up.

The DOC stated that they recognized the directions for head injury routine monitoring on the neurological record did not align with the directions in the home's policy. The DOC said they would expect the staff to follow the instructions on the neurological record. The DOC reviewed the three records listed for the identified resident and acknowledged that staff had failed to follow the procedures as documented on the neurological record or from the home's policy with respect to the timelines of the completing the checks; as well the DOC acknowledged that on two occasions staff had failed to waken the resident to complete the neurological check.

b) Review of Disposal of Discontinued/Expired drugs, Narcotics and Controlled Substances policy and procedure last reviewed January 17, 2017, under section 1e, it stated that the following medications would be identified, destroyed and disposed of including medications that were no longer required due to being discontinued, or when a resident was discharged or deceased. Discontinued narcotics and controlled substances were to be removed from the medication cart and the individual Narcotic and Controlled Substance Administration Record signed and dated prior to being placed into the double locked centralized storage area within the home. The individual Narcotic and Controlled Substance Administration Record should be included with the discontinued card in order to allow reconciliation at the time of destruction. In addition, the Narcotic and Controlled

Substances Surplus Drug form was also to be completed (or as per facility policy) when placing medication awaiting disposal in the double locked centralized storage area (i.e. wooden narcotic box) within the home. This form included documentation of the date of removal of the drug from the unit, resident name, prescription number, drug name, drug strength, quantity, and reason for removal.

The home used a "mailbox" to dispose of narcotic and controlled substances until the medication could be destroyed.

Observations at the time of the inspection showed a Narcotic and Controlled Drug Surplus record form was left on the top of the box to be completed with the information as listed above. The home had an area for a registered staff member and a registered staff witness to sign. In addition there were areas for the Director of Care or designate and pharmacist to complete upon destruction of the medication. An entry for a specified date was signed and completed by the registered staff and witness. A second entry did not include a witness to the disposal of a specified narcotic.

The RN and RPN said the process for disposing of narcotic and controlled substances was to put it in the mailbox and co- sign for the disposal. They reviewed the Narcotic and Controlled Drug Surplus Record Form with the two entries and acknowledged the disposal for one of the medications had not been witnessed.

The DOC stated that the expectation was that narcotic and controlled substances that were being discarded would be placed in the mailbox and there should be a witness to this process. The DOC reviewed the Narcotic and Controlled Drug Surplus form and acknowledged that there should have been a witness to the disposal of the identified narcotic but there was no witness documented.

The licensee failed to ensure that the home's Falls Program policy and Disposal of Discontinued/Expired drugs, Narcotics and Controlled Substances policy and procedure were complied with.

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC). The report made reference to a written complaint received by the home which included concerns surrounding bathing issues for a specified resident. Family of the resident were concerned that efforts to support the home and the resident's special needs with respect to bathing were not being appreciated. The complaint stated that half of the resident's baths over a two month period had either not been given or were not taking place at the previously scheduled times.

The plan of care for the resident stated that baths were to take place at specified times as arranged with the SDMs.

Review of the point of care (POC) bath report for the resident during the time period identified by the SDMs, showed that the resident received three out of five baths. Documentation indicated that when baths did take place, they were not always given at the specified time.

During interviews with a Personal Support Worker (PSW) and RN they said that the identified resident's SDMs had made arrangements for the resident to have their bath at a specified time to allow for added support. The PSW and RN shared that often baths did not take place at this time because the bath shift was pulled to work in another area. The resident either got their bath at another time or it was missed.

The Director of Care acknowledged receipt of the concern from the resident's SDM regarding bathing. The DOC said the direction to staff was that they were to bathe the resident at a specific time which would allow for added support. Based on the home's investigation related to the concern, the DOC stated that the resident did not always get a bath twice a week, and when they were bathed it was not always at the specified time identified in the plan of care.

The licensee failed to ensure that the resident was bathed at a minimum twice a week by a method of his or her choice. [s. 33. (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 the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A resident had a change in health status and was sent to hospital for assessment. After being evaluated in hospital they returned to the home.

Progress notes when the resident returned from hospital identified that they were experiencing pain. Over a three day period the resident either reported pain or exhibited signs of pain on a number of occasions. On the third day the resident was sent back to hospital where they were identified as having an injury. The electronic Medication Administration Record (eMAR) for the identified time period showed that the resident had not taken any PRN (as needed) medication for pain control during the five days prior to the incident. Following the incident, the resident was given PRN medication on three occasions and was reporting high levels of pain on the numerical pain scale.

Review of the assessments on Point Click Care did not show evidence of an assessment related to pain.

The home's Pain Management Program policy, effective December 23, 2015, and revised March 1, 2015, provided direction to staff to promote residents' comfort through assessment, management and treatment for pain.

A RPN stated that every shift they looked at pain with behaviours, health complaints, if the resident's mood was concerning. They stated that there was a pain assessment under assessments on PCC or they could document pain in a progress note. They said PAINAD assessments were usually not done unless it was a routine for the resident.

The Director of Care stated that the identified resident came back from hospital after being assessed and was complaining of pain in a specified area. When asked the expectation for completing pain assessments, the DOC said there should have been a pain assessment completed when the resident returned from hospital. When asked what should be done if pain control interventions were ineffective, the DOC said staff should complete a full pain assessment of the resident. They reviewed documentation on PCC and acknowledged that a pain assessment had not been completed for the identified resident.

The licensee failed to ensure that when the identified resident's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

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's pain was not relieved by initial interventions the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

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Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 6th day of November, 2018

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

Original report signed by the inspector.