Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
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Original Public Report

Report Issue Date: December 15, 2022

Inspection Number: 2022-1533-0002

Inspection Type:
Complaint
Critical Incident System

Licensee: Corporation of the County of Bruce

Long Term Care Home and City: Brucelea Haven Long Term Care Home - Corporation of the County of Bruce, Walkerton

Lead Inspector	**Inspector Digital Signature**
Kim Byberg (729)	Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2022.12.21 13:40:40 -05'00'

Additional Inspector(s)
Dianne Tone (000686) present during inspection.

INSPECTION SUMMARY

The Inspection occurred on the following dates:
November 29, 30, December 1, 5-9, 13, 2022.

The following intakes were inspected during this Critical Incident (CI) inspection:

- Intake: #00003425, related to fall prevention
- Intake: #00006137, related to staffing and resident care and services
- Intake: #00011035, related to an allegation of abuse towards a resident

The following intakes were inspected during this Complaint inspection:

- Intake: #00007701 and intake #00011032 related to retaliation and resident care and services

The following **Inspection Protocols** were used during this inspection:

Falls Prevention and Management
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Staffing, Training and Care Standards
Prevention of Abuse and Neglect

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The Licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard, as issued by the Director, was implemented.

The IPAC Standard for Long-Term Cares Homes, dated April 2022, section 9.1 stated at a minimum, additional precautions shall include point of care signage that enhanced IPAC control measures are in place.

Specifically, the licensee failed to post contact precaution signage at the door of two residents that required additional precautions.

During the inspection it was observed that two resident rooms had a personal protective equipment (PPE) cart inside the door of their room. No additional precautions signage was observed on the door or surrounding areas to indicate the need for PPE. A Personal Support Worker (PSW) and a Registered Practical Nurse (RPN) stated that the residents required additional contact precautions when providing direct care, and signage should have been present on the entrance to their room.

The following day additional contact precautions signage was observed on the resident doors.

Sources: Observations of two resident rooms, Interview with a PSW, RPN, and IPAC Lead, Routine Practices and Additional Precautions in all health care settings 3rd edition, third Revision: November 2012

Date Remedy Implemented: December 1, 2022

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WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that an allegation of abuse related to a resident was reported to the Director immediately.

Rationale and Summary
The home submitted a critical incident (CI) report to the Ministry of Long-Term Care (MLTC) related to an allegation of abuse towards a resident that occurred three days before it was reported to the MLTC.

The Administrator confirmed that the home should have reported the allegation of abuse to the Director immediately.

The potential risk of harm to the resident may have occurred as the Director was unable to take action, if required.

Sources: Interview with Administrator, and PSW. Review of the CI, and home's investigation notes.

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WRITTEN NOTIFICATION: Administration of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee has failed to ensure that a resident had a medication administered in accordance with the directions for use specified by the Physician.

Rationale and Summary
A resident was prescribed a medication by a Physician to be administered daily at 1400 hours. On a specified date, an RPN administered the medication two hours and twenty minutes earlier than prescribed.

The RPN stated the medication was not given within the one-hour window of the administration time. They did not call the Physician to communicate their assessment or obtain direction to administer the medication earlier than prescribed.

The home's Clinical Support Nurse (CSN) stated the medication was not administered as it was ordered by the Physician.

The resident received their prescribed medications earlier than the directions prescribed by the physician and put the resident at risk for an adverse drug reaction that may have required additional medical intervention.

Sources: Interview with an RPN and CSN. Record review of the resident's progress notes, electronic medication administration record (eMAR), medication audit, and physician orders.

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WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

The licensee has failed to ensure that when a resident received their medications at a time not prescribed for the resident, that an incident report was documented, and immediate actions taken to assess and maintain the residents health were completed.

Rationale and Summary
A resident was administered a medication two hours and twenty minutes earlier than prescribed.

A review of the home's medication incident reports did not show that a medication incident report was documented.

The RPN stated they were not aware that administering a medication earlier than prescribed was a medication incident.

The Medisystem Pharmacy defined a medication incident as a medication that was administered at a time other than what was prescribed.

The RPN did not complete a medication incident report after administering a medication earlier then prescribed and may have put the resident at risk for future incidents. The incident was not documented and did not provide for follow up of the resident's clinical status or corrective action after the incident.

Sources: Interview with RPN's and the CSN. Review of the home's medication incident reports, Medisystem definitions for medication incidents, Policies and Procedures: Manual for Medisystem service homes page 56 last updated August 2021, College of Nurses Medication Standards last updated June 2022, and Point click care (PCC) warning message.

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