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
Sep 26, 2018	2018_730593_0006	013266-18	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

GILLIAN CHAMBERLIN (593), LYNE DUCHESNE (117)

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): June 21 - 22, 25 - 29, 2018.

In addition, three intakes were inspected during the RQI. One complaint log #019024-17 related to resident care concerns, two critical incidents (CIS) log #004142-18 related to alleged resident to resident abuse and log #006159-18 related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nursing Staff, Registered Dietitian, Dietary Staff, Activation Staff, Housekeeping Staff, Personal Support Workers (PSW), residents and family members.

The inspector(s) observed the provision of care and services to residents, medication administration, staff to resident interactions, resident to resident interactions, residents' environment, reviewed resident health care records, investigation records and licensee policies.

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

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

4 WN(s)
2 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. 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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy (b) is complied with.

As per O.Reg. s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home has a policy "3-006 Medication Systems", revised May 7, 2018 that identified the following:

"Medication Reconciliation is the formal process of obtaining a completed and accurate list of each patient's current medications including name, dosage, frequency and route, using at least two sources. The reconciled list will be reported to The Admission/Discharge/Transfer (ADT) Form and/or Best Possible Medication History Form (BPMH). When comparing medication sources, any discrepancies identified should be brought to the attention of the prescriber and, if appropriate changes, made to the orders." (Page 1 of 6)

"….the Best Possible Medication History (BPMH)/Physician Order Form. Enter the resident information such as Resident Name, Date of Birth, Facility, Gender, Room Number, Admission Date, Conditions/Diagnoses, Allergies, Diet and Crush Meds

information." (Page 1 of 6)

On June 27 and 28, 2018, Inspector #117 reviewed the home's medication incident reports for the last quarter. It was noted that a medication incident was reported whereby resident #014 was administered a prescribed medication for which the resident was identified as being allergic.

The unit RN #122 contacted the resident #014's attending physician to let them know of a received laboratory test result indicating that resident #014 was positive for an infection. The attending physician prescribed a medication. RN #122 took the telephone order and administered a dose of the medication at 1300 hours from the home's emergency medication box. The medication orders were also faxed to the pharmacy provider that same afternoon for processing. Progress notes and eMAR indicated that resident #014 received the medication at 1300 hours that day, twice the next day and at 0800 hours the day after. On this last day the medication was administered, the home's pharmacy provider contacted the home and notified them that the resident was identified as having an allergy to this particular medication. As per reviewed progress notes and the medication incident report, resident #014 was immediately assessed, no adverse reactions were noted. The resident's attending physician was notified of the resident allergy, the administered four (4) medication doses and of the resident's health status. The medication was immediately discontinued and a new medication was ordered. The resident's substitute decision maker was also notified of the medication incident.

The home's Administrator reviewed the medication incident report, the resident's health care record and the internal investigation report with the inspector. The resident's health care record indicated in the Best Possible Medication History as well as on the resident MAR and medication reconciliation forms that the resident had an identified allergy to this identified medication. The Administrator said that when medication orders are received, the registered staff are to review the resident's Best Possible Medication History Form (BPMH) and MAR which included the verification of the resident's identified allergies. The Administrator stated that in this incident, the RN #122 did not verify the resident's Best Possible Medication History form and MAR that identified the resident's medication allergy before administering the newly prescribed medication to the resident and did not bring the resident's identified medication allergy to the prescribing physician's attention. [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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy (b) is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the medication for residents #016 and #023 were administered to residents in accordance with the directions for use specified by the prescriber.

On June 27 and 28, 2018, Inspector #117 reviewed the home's medication incident reports for the last quarter. It was noted that a medication incident was reported whereby resident #016 was administered an extra dose of a specific prescribed medication.

Resident #016 had a medical order for a particular medication. The resident's electronic Medication Administration Record (eMAR) indicated that the resident was to receive the medication at 0500 hours and at 1700 hours. For one day, the resident was administered this particular medication at 0448 hours, at 0800 hours and at 1742 hours. The medication error was identified during a narcotic shift count.

The home's Administrator reviewed the medication incident report and the internal investigation report with the inspector. It was noted that the resident was immediately assessed once the medication incident was discovered by RN #111. The resident #016's

vital signs were stable and no adverse effects were noted. The resident's attending physician and substitute decision maker were advised of the medication incident. The Administrator said that the RPN working on the day of the medication error, did not administer resident #016's medication in accordance with the directions for use specified by the prescriber.

On June 27 and 28, 2018, Inspector #117 reviewed the home's medication incident reports for the last quarter. It was noted that a medication incident was reported whereby resident #023 was administered their prescribed medication sooner than the prescribed time.

Resident #023 had a medical order for a specifc medication to be administered every six hours prn (as needed). The resident's eMAR indicated that the resident received their prescribed medication at 2130 hours on a specific day. The following day at 0130 hours, resident #023 was expressing pain. RN #121 administered the prescribed medication at 0130 hours. The medication was administered at four hours instead of the prescribed six hours since the last administered dose. RN #121 immediately reported the medication error and assessed the resident. No adverse effects were noted. The resident's physician and SDM were also notified of the medication error.

The home's Administrator reviewed the medication incident report and the internal investigation report with the inspector. The Administrator said that RN #121 did not administer resident #023's medication in accordance with the directions for use specified by the prescriber. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for resident #004 was provided as per the plan.

A review of resident #004's current plan of care found that the resident was a high nutritional risk and was to be provided a regular diet with a specific texture.

A review of a recent nutrition referral, found that the Registered Dietitian (RD) changed resident #004 from a specific textured diet to a different specific textured diet.

A progress note documented by the RD, indicated that resident #004 was to continue on this specific textured diet.

A review of the electronic physician's orders, found an order documented for the same specific textured diet.

A review of the kitchen dietary data sheets June 26, 2018, found an entry for resident #004 that documented a specific textured diet.

During a dining observation of the lunch meal service in the second floor dining room June 26, 2018, Inspector #593 observed a meal of chicken breast, baby potatoes and spinach served to resident #004. The meal was not the texture as indicated in the residents' plan of care. The resident appeared to be struggling to eat the meal with a knife and fork. It was brought to the attention of PSW's #102 and #103 who both confirmed that resident #004's meal was supposed to be a different texture.

During an interview with Inspector #593, June 26, 2018, PSW #102 reported that resident #004 was on a regular diet but the kitchen manipulated it to be a specific texture as the resident was a choking hazard. PSW #102 further added that during breakfast that morning, the resident was given a waffle but they did not eat it as they thought there was something wrong with it. The staff then brought the resident a bowl of rice krispies, which the resident ate. During a dining observation of the breakfast meal service in the second

floor dining room, June 26, 2018, Inspector #593 observed a whole waffle given to resident #004. The waffle was not the texture as indicated in the residents' plan of care and the resident did not eat the waffle.

During an interview with Inspector #593, June 27, 2018, RD #113 reported that resident #004 was admitted to the home on a regular textured diet however, the RD was not comfortable with how the resident was chewing on a regular diet and so they changed them to a specific textured diet. The RD further reported that resident #004 was refusing to eat this specific texture, and as a result, they changed them to a different specific textured diet. The RD confirmed that resident #004 should still be receiving this specific texture diet. [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the survey were made available to the Residents' Council, to seek their advice under subsection (3).

During an interview with Inspector #593, June 28, 2018, resident #025, president of the Residents' Council reported that the results of the resident satisfaction survey were not shared with the council members.

During an interview with Inspector #593, June 28, 2018, staff member #115, the assistant to the Residents' Council, reported that the 2017 resident satisfaction survey results had yet to be received by head office and so had not been shared with the Residents' Council. Furthermore, they were unsure if the 2016 results were shared with the council and were unable to locate any documentation to support that the results were shared with the council.

A review of the Resident Council minutes from January 2017 until June 2018, found no entries related to reviewing the results of the resident satisfaction survey with the Residents' Council. [s. 85. (4) (a)]

Issued on this 27th day of September, 2018

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

Original report signed by the inspector.