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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 29, 2018	2018_664602_0006	004791-18	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 Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

WENDY BROWN (602), CATHI KERR (641), SUSAN DONNAN (531)

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): March 13-16 and March 19-21, 2018.

Log# 003669-18 - regarding alleged resident to resident abuse was inspected concurrently with the RQI.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSW), Dietary staff, Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care (DOC), Resident Care Coordinator, RAI-Coordinator, Program Manager, and the Administrator.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 20. (1) whereby the written policy to promote zero tolerance of abuse and neglect of residents was not complied with.

Under O. Reg.79/10 s. 2(1), sexual abuse is identified as any non-consensual touching, behaviour or remarks of a sexual nature directed towards a resident by a person.

On a specified date a critical incident was submitted to the Ministry of Health and Long Term Care.

In an interview on a specified date PSW #115 explained that they found resident #049 in resident # 041's room. Resident #041 was awakened by the touch of resident #049 and called out. Staff redirected resident #049 from the room. The PSW indicated resident #041 was settled; prior to reporting the incident to RPN #107. In a subsequent interview, RPN #107 indicated that when PSW #115 reported the incident they then reported the incident to RN #120 as per policy.

RN #120 was interviewed and indicated that there were two critical incidents involving resident #049 on the specified date. The RN advised that the second incident required immediate response and treatment. RN #120 indicated that when reporting the second incident they forgot to notify the Administrator of the first incident with resident #041, thus, the Director was not notified of the first incident as per policy.

Review of the "Abuse and Neglect Schedule D page 5 Mandatory Reporting: Procedure reads:
1) All cases of suspected or actual abuse must be reported immediately in written form to the Director of Nursing/Administrator. In the absence of management staff, concerns should be reported immediately to the charge nurse, who will notify the management staff on call, who would then notify the Director.

Subsequently the Administrator was interviewed and acknowledged that the home's written policy to promote zero tolerance of abuse and neglect of residents was not complied with. [s. 20. (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 staff follow the Abuse and Neglect Mandatory Reporting procedure, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #041's Substitute Decision Maker (SDM) was immediately notified of alleged incident of abuse.

On a specified date a critical incident specific to resident to resident abuse was reported to the Ministry of Health and Long Term Care.

In an interview on a specified date PSW #115 explained that they found resident #049 in resident # 041's room. Resident #041 was awakened by the touch of resident #049 and called out. Staff redirected resident #049 from the room. The PSW indicated resident #041 was settled; prior to reporting the incident to RPN #107. In a subsequent interview, RPN #107 indicated that when PSW #115 reported the incident they then reported the incident to RN #120 as per policy.

RN #120 was interviewed and indicated that there were two critical incidents involving resident #049 on the specified date. The RN advised that the second incident required immediate response and treatment. RN #120 notified the SDMs involved of the second critical incident however the RN explained that they forgot to immediately notify resident #041's SDM regarding the first incident. In a subsequent interview with the Administrator the Critical Incident report was reviewed and the Administrator acknowledged that resident #041's SDM had not been immediately notified. [s. 97. (1) (a)]

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 no drug was administered to a resident unless

the drug had been prescribed for the resident.

A medication incident report indicated that RN #117 failed to ensure that resident #045's medication review had been processed completely, resulting in the resident receiving a medication for a specified number of days that was no longer prescribed.

During an interview, the Director of Care (DOC) noted that resident #045's physician had completed a medication review. The medication review form was to be faxed to the pharmacy for processing. It was RN #117's responsibility to ensure that the orders were processed completely on the electronic medication administration report (eMAR). There had been two medications that the physician discontinued and the pharmacy only discontinued one of the medications on the eMAR leaving the second medication on the eMAR. RN #117 did not note that this medication was discontinued, thus, the medication remained on the resident's eMAR as a current medication.

The DOC clarified that a staff member had reordered the no longer prescribed medication but it was not shipped to the home. A notation was put on the eMAR at that time indicating the order was pending. On a specified date when the resident required more of the medication, the home was notified by the pharmacy that the medication had been discontinued a specified number of days earlier. Resident #045 received a specified medication for a period of days after it had been discontinued. No ill effects on resident #045 were noted.

The DOC indicated that there had been two errors made that contributed to the medication not having been discontinued as ordered and resident #045 receiving the medication for multiple days without an order. The pharmacy had not removed the medication from the eMAR and RN #117, who was responsible to review the orders, did not note the medication remained on the resident's eMAR.

The licensee failed to ensure that no drug was administered to resident #045 unless it had been prescribed. [s. 131. (1)]

2. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

A medication incident occurred on a specified date and indicated that RPN #110 administered the wrong type and dose of a medication to resident #046.

Resident #046 had a physician's order for a specific type of medication during the day and another type of medication in the evening.
During an interview the DOC indicated that the medication incident had occurred because RPN #110 had not looked closely at the medications for resident #046. RPN #110 had given the evening medication instead of the day time medication . The DOC indicated that the physician, resident and family were notified about the incident.

Another medication incident was reviewed and indicated that resident #046 had received the wrong strength of medication for a specified period of days.
During an interview regarding this medication incident the DOC indicated that resident #046 had been receiving a specific dosage/strength of medication before transfer to the home. On admission, the resident's physician had prescribed the same dosage/strength of the medication which was noted in resident #046's chart. Subsequently, the pharmacy contacted the physician directly to inform the doctor that the dosage/strength that resident #046 had been receiving was not eligible for Ontario Drug Benefits(ODB) now that the resident is living in a Long Term Care home. Resident #046's doctor then changed the order at the pharmacy to a different strength and dosage, that was covered by ODB, and the medication was sent to the home reflecting the new order. The licensee had no record of this order in the resident's chart since the second order had not been communicated to the home by either the resident's doctor or the pharmacy. The medication was administered daily for a period of days until it was noted that the strength of the medication was not what had been ordered in resident #046's chart. The DOC specified that the registered staff had been documenting the strength of the medication two to three times per day without actually observing the label for dosage strength.
Resident #046 received the wrong strength of medication for a period of multiple days.

The licensee failed to ensure that drugs were administered to resident #045 and #046 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 4th day of May, 2018

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

Original report signed by the inspector.