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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 29, 2016	2016_328571_0021	007584-16, 013091-16, 034537-15, 011093-16	Complaint

Licensee/Titulaire de permis

The Royale Development GP Corporation as general partner of The Royale Development LP
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Case Manor Care Community
28 BOYD STREET P.O. BOX 670 BOBCAYGEON ON K0M 1A0

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

PATRICIA MATA (571), SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 22, 25, 26, 27, 28, 29, 2016.

The following complaint logs were inspected:
034537-15 re: consent for care; 013091-16 re: consent for care and medications; 007584-16 re: nutrition; and 011093-16 re: multiple care issues.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, two Associate Directors of Care, Director of Dietary Services, Dietitian, Dietary Aide, Physician, Nurse Practitioner, Registered Nurses, Registered Practical Nurses, Personal Support Worker and residents.

In addition, several licensee policies were reviewed, clinical records, written complaints and investigations, administrative records.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **6 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #002 was based on an assessment of the resident and the resident's needs and preferences and that the resident was given an opportunity to participate fully in the development and implementation of his/her plan of care.

Related to Complaint Log #007584-16:

An anonymous complaint received via the Action Line on a specified date regarding resident #002. The complaint indicated resident #002 had been asking to have one egg every day at breakfast and the request was refused.

Resident #002's plan of care indicated that the resident can make his/her own decisions related to how to spend their time, and how to complete activities of daily living.

On July 25, 2016 during an interview, resident #002 indicated that breakfast was his/her favourite meal of the day and that his/her preference was to have an egg every day. The resident indicated that eggs used to be served daily and then the licensee changed the menu. Resident #002 had formally requested on two occasions to have eggs every day and was denied by Registered Dietitian (RD) #104. Resident #002 was unsure of the reason the request was denied and stated that no one ever followed up regarding his/her request. Resident #002 was not consulted by the RD #104 when the resident's request for eggs daily was considered and believes the RD#104 spoke to a family member. The resident does not like three of the protein options offered when eggs are not served. The resident stated he/she needed to eat at every meal related to a medical condition and

therefore has had an egg at breakfast all his/her life.

During an interview on July 26, 2016, Director of Dietary Services (DDS) #103 indicated there have been three other requests for eggs daily over the last six months from different residents. The three other residents were currently receiving eggs daily as it was their preference. DDS #103 indicated that residents' needs and preferences were usually considered and accommodated if the request was "simple". DDS #103 stated was not aware that resident #002 did not like the three other protein options. The DDS #103 was unsure what protein options would be offered to resident #002 on days that those specific three protein items were on the menu. The DDS was aware that resident #002 has a specified medical condition.

A review of the Dietitian referral on a specified date indicates a request for eggs at breakfast. The referral was reviewed by RD #104 eight days later. The RD's assessment indicates that resident #002's weight and body mass index and intake was reviewed; the egg request was a personal preference, no nutritional indication existed therefore request was denied.

A second Dietitian referral on a specified date one month later, indicates as per progress notes that the Substitute Decision Maker (SDM) of resident #002 was requesting that the resident have eggs offered at breakfast daily as this has been causing resident #002 to be very upset at breakfast time and that the previous referral was denied; please speak to SDM about this.

This referral was reviewed 10 days later by RD #104. The RD's assessment indicates that the RD and ADOC phoned SDM and was explained that there is no other nutritional indication and that the resident was receiving eggs three days currently; behaviour issues discussed and only one situation of resident #002 being extremely upset about eggs was recalled; SDM did inform RD #104 that resident #002 does not like two protein options; change in menu and resident council vote to keep current menu was explained. The plan was to continue with regular menu unless behaviours occurred frequently or intake appeared to be greatly affected by resident being upset, in which SDM would contact staff to have issue re-examined. The request was denied.

During an interview on July 27, 2016 the Registered Dietitian (RD) #104 stated that the menu was changed to remove daily eggs by a vote of the residents at food committee so that there would be a variety of choices in the breakfast menu. RD #104 confirmed that

resident #002 is capable of making his/her own decisions and that resident #002's initial request for eggs daily was submitted on a specified date. The RD confirmed that the assessment at that time was to review the documented meal intake records for resident #002, current weight and body mass index (BMI). The RD confirms that at that time he/she did not meet with resident #002 to discuss the request. This request was denied because there was no "nutritional indication" requiring eggs daily. RD #104 confirmed that he/she reviewed the second request from the SDM of resident #002 for eggs to be offered at breakfast daily. The RD confirmed that when this request was received an analysis of resident #002's recent meal intake, weight and BMI was not completed. This referral was completed with a phone call by the RD and ADOC #105 to resident #002's SDM to explain that the rational for not providing eggs daily as per resident request was due to the request being based on personal preference and not nutritional need . The RD confirmed that the resident was not involved in the care planning process and only became aware of resident #002's dislike of two of the protein choices 10 days after the second referral when informed by SDM. The RD was not aware that the resident did not like the third protein choice. As of July 27, 2016, the RD had not updated the plan of care or met with the resident.

Therefore the licensee failed to ensure that resident #002 was given an opportunity to participate fully in the development and implementation of the resident's plan of care related to nutrition, including discussion of the resident's needs and preferences related to protein options for a specific medical diagnosis. [s. 6. (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 by ensuring that the resident is given an opportunity to fully participate in the plan of care related to nutrition and that the plan of care is based on the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaints that have been received concerning the care of a resident of the operation or the home are immediately forwarded to the Director.

Related to Complaint Log #034537-15:

During an interview on July 22, 2016 at 1500 hours the Executive Director (ED) confirmed that he/she received a written complaint from the Substitute Decision Maker (SDM) for resident #001 on a specified date. The ED confirmed that the written complaint stated that the SDM for resident #001 felt that "MD #110 (physician) was going against the wishes of the SDM by prescribing, and administering anti-psychotics and anti-depressant medications to resident #001". ED confirmed that this original complaint letter concerning the care of resident #001, was never forwarded to the Director. [s. 22. (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 a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. Pursuant to The Health Care Consent Act, 1996 Part 1 General, Interpretation 2. (1), "treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include, (a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the Substitute Decisions Act, 1992 of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,(b) the assessment or examination of a person to determine the general nature of the person's condition, (c) the taking of a person's health history, (d) the communication of an assessment or diagnosis, (e) the admission of a person to a hospital or other facility, (f) a personal assistance service, (g) a treatment that in the circumstances poses little or no risk of harm to the person, (h) anything prescribed by the regulations as not constituting treatment. ("traitement") 1996, c. 2, Sched. A, s. 2 (1); 2000, c. 9, s. 31; 2007, c. 8, s. 207 (1); 2009, c. 26, ss. 10 (1, 2); 2009, c. 33, Sched. 18, s. 10 (1).

In addition, "course of treatment" means a series or sequence of similar treatments administered to a person over a period of time for a particular health problem; "plan of treatment" means a plan that, (a) is developed by one or more health practitioners, (b) deals with one or more of the health problems that a person has and may, in addition, deal with one or more of the health problems that the person is likely to have in the future given the person's current health condition, and (c) provides for the administration to the person of various treatments or courses of treatment and may, in addition, provide for the withholding or withdrawal of treatment in light of the person's current health condition.

Health Care Consent Act 1996, c. 2, Schedule. A, s. 10 (1), a health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless, (a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or (b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Under the LTCHA, 2007, s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (a) a goal in the plan is met; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective.

The licensee of the long-term care home failed to ensure that when a resident is reassessed and the residents plan of care is reviewed and revised under subsection 6(10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under the Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised.

Related to Complaint Logs #034537-15 and #013091-16:

A complaint was made to the Director on a specified date from the Substitute Decision Maker (SDM) for resident #001. The SDM indicated that MD #110 was disregarding the decisions of his/her medical Power of Attorney (POA) for resident #001. MD #110 was providing treatment to resident #001 against the wishes of the SDM and without consent. The SDM also indicated that he/she was no longer being informed about any change made to resident #001's medication.

Review of the Annual Care Conference Summary for resident #001 on a specified date, indicated that the SDM wanted the resident to receive analgesic for pain control and to be taken off of a specific medication. The SDM's wishes for the resident is to keep resident #001 comfortable and pain free. The SDM wants the resident cared for as the resident would have wished.

A review of a copy of an email provided by the Executive Director indicated that on a specified time and date, MD #110 emailed the SDM for resident #001. The email included the physician's credentials and an explanation for the use of several medications and the rational for these medications being prescribed for resident #001.

One day later, the SDM responded to the MD #110 by directing the MD to not use two specific types of medication for resident #001.

Twenty eight days later, a progress note indicated that the SDM contacted Associate Director of Care (ADOC) #105 after receiving a pharmacy bill that indicated resident #001 had been billed for a specific type of medication. The SDM indicated to ADOC #105 that the physician was not to prescribe two specific types of medication for resident #001.

Four days after the SDM contacted the ADOC about the pharmacy bill, a progress note indicated that the SDM for resident #001 instructed ADOC #105 that he/she wanted resident #001 taken off of all medications except for pain medications. ADOC #105 instructed the Registered Nurse (RN) on the floor to contact the MD to have all non-pain medications discontinued.

Review of the medical records from a specific 41 day period starting six days after the SDM originally instructed MD #101 not to order two specified types of medication for resident #001, indicated that on six different dates, MD #110 ordered, or increased dosages for these medications.

Review of the progress notes for resident #001 for the same 41 day period fails to identify whether the SDM for resident #001 was informed of the changes in the "plan of treatment" or if consent was given for the changes in the "plan of treatment" that occurred during the 41 day time period. In addition, the SDM indicated to ADOC and the Executive Director that resident #001 had made his/her end of life care wishes clear to the SDM and therefore, the SDM wanted the licensee to stop administering two types of medicaiton previously mentioned. The SDM also indicated that he/she had consulted outside medical professionals for advise on the administration of these drugs.

A second email written by the SDM during the 41 day time period, addressed to the Executive Director was reviewed. This email indicated that the initial email had also been copied to the Executive Director on that date demonstrating that he/she was aware of the request that resident #001 was not to receive the two specific types of medication. The

SDM requested a meeting with the ED and MD #110 "as soon as possible to sort this mess out" and requested immediate confirmation that resident #001 was not being administered the specified medications.

In Summary, the SDM for resident #001 instructed either Md #110, ADOC or ED on four different dates to stop giving the two types of medications to resident #001.

The directions of the SDM for resident #001 regarding medications was not followed until another health care provider assumed care on a specified date.

Therefore the licensee failed to ensure that when resident #001 was reassessed and the resident's plan of care was reviewed and revised that consent or directive with respect to a "course of treatment" or a "plan of treatment" was reviewed and, if required, revised. [s. 29.]

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 is reassessed and their plan of care is reviewed and revised any consent or directive with respect to "treatment" is reviewed and, if required, revised, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee of a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

Related to Complaint Log #034537-15:

During an interview on July 22, 2016 at 1500 hrs, the Executive Director (ED) confirmed that he/she received a written complaint from the Substitute Decision Maker (SDM) for resident #001 on a specific date. The ED confirms that the complaint stated that MD #110 was going against the wishes of the SDM as the MD was prescribing, and administering two types of medication to resident #001. The email indicated that the SDM wanted confirmation that day that the medication was not being administered. The ED stated that a meeting was held two days later with the SDM, DOC #109 and the ED to discuss the complaint. The ED confirms that this meeting was held after the Form G was filed with the Capacity and Consent Board on the day before, to request a review by the Board of the SDM's suitability as power of attorney for resident #001. The ED stated that the meeting was short and was concluded without resolution. The ED confirms that no further investigation into the complaint was completed, nor was a resolution found and a response was not provided to the complainant by the ED.

Therefore the licensee failed to immediately investigate the complaint that alleged harm or risk of harm to resident #001, resolve where possible and respond within 10 business days of receipt of the complaint. [s. 101. (1) 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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as per O. Reg. 79/10, s. 101 (1), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Review of the health care records for resident #001 included the medication administration record (MAR) for a specific 72 day period. The MAR indicated that a specified medication was administered 64 times. There 32 times where the effectiveness of the medication and the residents response was not clear or not documented.

During an interview on July 28, 2016 the DOC #106 confirmed that when the registered nurses administers a PRN medication, the expectation of the home is that they will document the following: the reason for administering the medication, the residents response to the medication and the effectiveness of the drug.

DOC #106 reviewed the progress notes for resident #001 for the specific 72 day period. The DOC confirmed that the documentation for PRN medication is not always being completed and the effectiveness is not always describing the resident's response to the medication. It is the homes expectation to provide a timely, detailed response for PRN medications being administered.

The monitoring and documentation of resident #001's response to specific medication is not clear and the documentation of the effectiveness of the psychotropic medication was not always completed. [s. 134. (a)]

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 there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff record the symptoms of infection in residents on every shift.

Re: Complaint Log # 011093-16:

A written complaint was received by the Director regarding concerns with issues related to care for resident #010.

A review of the progress notes for resident #010 indicated that the resident had an specific incident during a meal on a specified date. Registered Practical Nurse (RPN) #115 responded to the incident. Eighteen days later, the resident had specified symptoms of infection and MD #110 ordered a specified medication as necessary for the next one to two days and if no improvement to call the MD for further direction.

A progress note by MD #110 dated four days later, indicated that resident #010 had worsened symptoms and a medication was ordered stat and then once a day for seven days and two other medications for seven days.

A review of the progress notes indicated that a record of signs and symptoms of infection for resident #010 could not be found on all shifts over a ten day period despite resident #010's condition deteriorating.

Therefore, the licensee failed to ensure that staff recorded the signs and symptoms of resident #010's infection on every shift. [s. 229. (5) (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 on every shift the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #7: 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Re: Complaint Log #011093-16:

A review of the progress notes indicated that on a specific date, resident #010 had specific symptoms of infection. The Medical Doctor (MD #110) ordered a specific medication as necessary. Four days later, MD #110 ordered a STAT medication.

In a progress note, Registered Nurse (RN) #114 documented that the medication came in from medical pharmacy but he/she could not sign it in so the medication was not given until 2100 hrs.

A review of the "Emergency Starter Box Master List" completed by a Medical Pharmacy staff during a pharmacy audit the day before the medication was ordered, indicated that there were two packages of the specified medication available in stock in the home for emergencies.

Therefore, RN #114 failed to give the first dose of a stat medication as ordered by the physician despite having access to the drug immediately. [s. 131. (2)]

Issued on this 29th day of August, 2016

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

Original report signed by the inspector.