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

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Amended Public Copy/Copie modifiée 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
Dec 11, 2019	2019_583117_0055 (A1)	022545-19	Critical Incident System

Licensee/Titulaire de permis

Centre d'Accueil Roger Seguin
435 Lemay Street Clarence Creek ON K0A 1N0

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

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435 Lemay Street Clarence Creek ON K0A 1N0

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

In the Public Inspection report, a paragraph had been repeated twice in the finding under LTCHA s. 6 (5). The repeated paragraph was removed.

Issued on this 11st day of December, 2019 (A1)

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

Original report signed by the inspector.

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

Amended by LYNE DUCHESNE (117) - (A1)

Amended 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): December 2, 3, 4, 5 and 6, 2019

This inspection is in regards to Log # 022545-19, a critical incident report (CIS #C519-000020-19) related to an unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, a coroner, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs) as well as the home's staffing clerk.

During this inspection, the inspector reviewed an identified resident's health care record including medication orders and medication administration records, reviewed security video footage, reviewed the licensee's policies # SD-INF 2117.1 "Documentation in Professional Notes", revised July 2014, # SD-INF 2130 "Orders", revised July 2014 and # SD-INF 2131 "Orders verbal and/or by telephone", revised July 2014, as well as the licensee's internal investigation report.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

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

1 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 :

(A1)
1. The licensee failed to 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.

On a specified day in 2019, resident #001 was feeling unwell. RN #102 assessed the resident and noted that the resident had respiratory changes. At a specified time, RN #102 contacted the attending physician regarding the resident's change in health status. The physician ordered a treatment as well as a specified medication to be administered three times daily for seven (7) days, with the first dose to be administered that day. RN #102 applied the ordered treatment and then administered the prescribed medication to the resident.

As per the resident's health care record, the resident had cognitive impairments and was not able to give consent for the ordered medication and treatment. Resident #001's family member is their designated Substitute Decision Maker (SDM) for personal care and treatment decisions. RN #102 documented in the resident's health care record that the resident's SDM should be contacted the next morning to inform and obtain consent for the newly received medication and treatment orders.

The inspector spoke with RN #102 who said that they had not contacted the resident #001's SDM to obtain their consent prior to administering to the resident the new medication and treatment on the specified day in 2019. The RN indicated that they felt it was too late in the day to contact the SDM and noted that the SDM should be informed of the order and consent obtained the next day. The home's Administrator and Director of Care both said that the SDM should have been contacted shortly after the medication order and treatment were received and consent obtained prior to the administration of medication and treatment. [s. 6. (5)]

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, 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, to be implemented voluntarily.

Issued on this 11st day of December, 2019 (A1)

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

Original report signed by the inspector.