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

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Amended Public Report (A1)

Report Issue Date: February 15, 2023

Inspection Number: 2022-1488-0002

Inspection Type:
Complaint

Licensee: Centre d'Accueil Roger Seguin

Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek

Inspector who Amended the Report	**Inspector who Amended Digital Signature**
Joelle Taillefer (211)	Joelle Taillefer Digitally signed by Joelle Taillefer Date: 2023.02.15 11:38:54 -05'00'

Additional Inspector(s)

Amended Inspection Summary

This licensee inspection report has been revised to reflect the revision of a paragraph within Finding #002 under O. Reg 79/10, s. 114 (3) (a). The Complaint Inspection, #2022_1488_0002 was completed on January 23, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 28, 29, 30, 2022, December 1, 2, 13, 2022 (onsite) and December 19, 2022 (offsite)

The following intake(s) were inspected:

- Intake: #00005228-related to Medication Management and Resident Care and Support Services.

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

Medication Management
Staffing, Training and Care Standards

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 107 (1) 2.

The licensee has failed to ensure to immediately inform the Director, in as much details as is possible in the circumstances, of the unexpected or sudden death of a resident, followed by the report required under subsection (4).

Rationale and Summary:

A resident returned to the Long-Term Care (LTC) home on a given day in 2016, after being in hospital. The resident was alert, oriented, and accompanied by a family member. A device was used to transfer the resident at bedtime as the resident was having difficulty mobilizing and the resident stated having weakness.

The progress notes on a given day in 2016, indicated that at the start of a shift, the resident rang twice for two different reasons. At a given time, the resident was observed to be sleeping and breathing. An hour and a quarter later, the resident was found without vital signs. The notes indicated that a family member was contacted, and the attending physician was informed of resident's death.

Resident's plan of care dated on a given day in 2015, indicated that the resident had a specific advance directive and no cardiopulmonary resuscitation.

Review of the resident's discharge summary documented by the hospital indicated that the resident was scheduled for a follow-up with an identified physician.

The DOC stated that the process when a resident dies, the physician will be contacted, and a Critical Incident Report will be sent to the Director if the death was considered unexpected or sudden.

As such, because the resident deceased within 12 hours of their return from hospital, the Director should have been informed immediately as this was an unexpected or sudden death.

Sources: Resident's health care records and interview with the DOC. [211]

WRITTEN NOTIFICATION: Medication Management System

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 114 (3) (a)

The licensee has failed to ensure that the written policies and protocols must be,
(a) implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:

In accordance with O. Reg. 79/10, s. 8 (1) (b), the licensee is required to ensure that their written interdisciplinary medication management system policy put in place was complied with.

Specifically, staff did not comply with the policy section 7-5 titled "Readmission des residents hospitalisés (Readmission of hospitalized residents)" dated in 2015 by their pharmacy service provider that indicated the following:
-The pharmacy must be notified of any changes to medication following readmission using the Medication Reconciliation form titled "Meilleur Schema Thérapeutique Possible (MSTP)".
-Perform medication reconciliation by comparing readmission order to MAR orders. Notify the prescriber in case of discrepancy.
-Share all hospital discharge summaries, medication reconciliation documents and hospital medication administration.

On a given date in 2016, a resident returned to the home from the hospital. The hospital's prescription and discharge notes identified which medications were to be stopped and continued, and the new medications to be started.

Inspector #211 reviewed the hospital's prescription and discharge information, and the Long-Term Care home's physician orders and the home's medication administration record (MAR) on a given date in 2016. The hospital's prescription and discharge information indicated to continue three identified medications, that were to be administered once per day.

The physician's orders from the home, on the day the resident returned from the hospital, written by a Registered Nursing Staff indicated which medications were to be continued. There was no documentation that the Registered Nursing Staff verified to which medications had been administered prior to the resident's return to the home.

The licensee's MAR indicated that on the day of the resident's return to the home, that three identified medications prescribed once a day were administered in the home.

The Administrator stated that one of the identified medications was administered on that day at bedtime as it was prescribed by the home's attending physician.

The DOC stated that the physician's orders, written by the Registered Nursing Staff on the day of the resident return of the hospital was the medication reconciliation.

The licensee was unable to provide the formal medication reconciliation sheets that were to be used as per the home's policy in 2016.

As such, the Registered Nursing Staff from the home did not use a formal medication reconciliation sheet to reconcile the resident's medications that were prescribed and administered at the hospital on the given date in 2016, with the licensee's physician order. Consequently, the resident was administered three of the medications twice on that given date in 2016, instead of once a day.

Sources: Resident's health care records from the hospital and the "Centre D'Accueil Roger Seguin", interviews with the DOC and the Administrator. [211]