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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 23, 2014	2014_284545_0017	O-000515-14	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LONGFIELDS MANOR
330 BEATRICE DRIVE, NEPEAN, ON, K2J-5A5

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

ANGELE ALBERT-RITCHIE (545)

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): June 26 and 27, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (DOC), Regional RAI Educator, RN Educator, two Registered Nurses (RN), several Personal Support Workers (PSW) and Resident #001.

During the course of the inspection, the inspector(s) reviewed Resident #001's health records, reviewed relevant policies & protocols, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Findings of Non-Compliance were found during this inspection.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c) in that the licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #001 was admitted to the home in 2002 with several medical conditions including heart disease, arthritis and a neurological condition. Resident #001 was receiving regular and PRN narcotics for pain management.

The Plan of Care dated dated March 2014 indicated that Resident #001 had a history of constipation with bowel obstruction and disliked prunes. It also indicated that Resident #001 had chronic pain and was administered daily narcotics for pain management. Documented interventions related to constipation providing clear directions to staff and others who provided direct care to Resident #001 were not found.

In an interview with PSW #S105, she indicated that Resident #001 routinely had bowel movements (BM). She indicated that documentation was done if Resident had a BM or not in the home's electric chart (Point of Care).

In an interview with PSW #S107 and #S104, they indicated that Resident #001 was incontinent of bladder and more recently of bowels but were not aware of other bowel

problems such as a history of constipation and bowel obstruction. They both indicated that they had access to the plan of care.

During an interview with RN #S103, she indicated that registered staff relied on PSW to document on every shift if resident had a bowel movement. RN #S103 indicated that due to missing entries on the electronic Bowel Record completed by the PSW, she found it difficult to know when to initiate the Bowel Protocol for Resident #001 and that it was not always administered as prescribed. RN #S103 indicated that Resident #001 was sent to hospital on a specific date in May 2014 for abdominal pain and was diagnosed with impacted bowel and urinary tract infection.

On June 27, 2014 during an interview with RN #S108, she indicated that Resident #001's bowels should be monitored very closely due to Resident's constipation history and daily use of narcotics and that missing entries by PSW should not be occurring. RN #S108 indicated that Resident #001's bladder should be monitored closely for burning and increase frequency due to recurrent urinary tract infections. RN #S108 indicated that the resident's plan of care should provide clear direction to direct care staff so they report Resident #001's bowels and bladder concerns to registered staff. [s. 6. (1) (c)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (4) (b) in that the licensee did not ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

In a review of Resident #001's Physician Medication Review for the period of beginning of March to end of May 2014, it was indicated that registered staff were to initiate the Resident Bowel Protocol if no bowel movement for 3 days, as follows:
• Bowel Protocol 1 - Milk of Magnesia 400mg/5ml – IF no bowel movement Day 3 give 30ml by mouth daily
• Bowel Protocol 2 - Glycerin Suppository—IF no bowel movement Day 4 insert 1 suppository rectally times 1 dose
• Bowel Protocol 3 - Sodium Phosphates Enema (fleet)—IF no bowel movement Day 5 insert 1 enema rectally times 1 dose

In a review of Resident #001's progress notes for the months of April and May 2014, it was indicated that Resident #001 had four episodes of constipation where the bowel

protocol was not followed.

On a specific date in May 2014 it was documented on the Pharmacist Recommendation Form by the consultant pharmacist and verified by RN #S103 that Resident #001 "had been experiencing frequent constipation recently and because Resident #001 was currently receiving narcotics, a suggestion review of potential benefit of the addition of a laxative like Senekot 8.6mg daily or Restolex or Lax-a-day daily" was made. As well, the consultant pharmacist was suggesting a "review for possible discontinuation of the prescribed antibiotic due to limited efficacy in reducing the occurrence of UTIs and increased risk for antimicrobial resistance".

During an interview with RN #S108, she indicated that she faxed the Pharmacist Recommendation Form dated a specific date in May 2014 to the home’s physician on a specific date in May 2014 (21 days following receipt of recommendation) and 2 days after Resident #001 was sent to hospital for a bowel impaction and UTI. RN #S108 indicated that Resident #001 returned to the home on a specific date in May 2014 with a recommendation from the Emergency physician for a specific antibiotic for 10 days and a specific laxative for 1 month. On a specific date in May 2014, after receiving the faxed Pharmacist Recommendation Form, the home’s physician immediately discontinued Psyllium Fibre and started Resident #001 on the recommended laxative and put the antibiotic on hold.

In an interview with the Acting Director of Care on June 27th, 2014 she indicated that the Pharmacist Recommendation Form should have been faxed as soon as it was received due to Resident #001’s constipation history. She also indicated that it was the responsibility of the registered staff to ensure that the physician was informed of the pharmacist recommendations.

During an interview with the Administrator on June 27, 2014 she indicated that she would be implementing a new process whereby a signature by a physician would be required on the Pharmacist Recommendation Form in order to validate that the form was reviewed.

As such the licensee did not ensure that the staff and others involved in the different aspects of care of the Resident #001 collaborate with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and consistent with and complemented each other. [s. 6. (4) (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 the plan of care set out clear directions to staff and others who provide direct care to Resident #001 in relations to bowel and bladder management, 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 comply with O. Reg. 79/10, s. 131 (2) in that the home did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Plan of Care dated a specific date in March 2014 indicated that Resident #001 had a history of constipation with small bowel obstruction and disliked prunes. It also indicated that Resident #001 had chronic pain and was administered daily narcotics for pain management.

In a review of Resident #001's Physician Medication Review for the period of beginning of March to end of May 2014, it was indicated that registered staff were to initiate the Resident Bowel Protocol if no bowel movement for 3 days, as followed:

• Bowel Protocol 1 - Milk of Magnesia 400mg/5ml – IF no bowel movement Day 3 give 30ml by mouth daily
• Bowel Protocol 2 - Glycerin Suppository—IF no bowel movement Day 4 insert 1 suppository rectally times 1 dose
• Bowel Protocol 3 - Sodium Phosphates Enema (fleet)—IF no bowel movement Day 5 insert 1 enema rectally times 1 dose

In a review of Resident #001's progress notes for the month of April and May 2014 it was indicated on four separate occasions that Resident #001's individual care physician orders for Bowel Protocol was not followed as specified by the prescriber:

Episode #1
• April 9, 2014—documentation of last BM (evening shift)
• April 13, 2014—MOM 30ml administered (Bowel Protocol 1)
• April 14, 2014—MOM 30ml administered, bowel sounds audible
• April 15, 2014—Resident says it has been a while since had a BM, prune juice given
• April 16, 2014—Hard stool felt, glycerin suppository inserted (Bowel Protocol 2)
• April 16, 2014—Large constipated BM (evening shift)

As such on Episode #1, Bowel Protocol 1 was initiated on Day 4.

Episode #2
• April 16, 2014—documentation of last BM (evening)
• April 23, 2014—glycerin suppository inserted (Bowel Protocol 2)
• April 24, 2014—no result, monitoring
• April 25, 2014 at 05:37—Fleet enema administered (Bowel Protocol 3)
• April 25, 2015 at 14:20—BM

As such on Episode #2, Bowel Protocol 1 was never initiated, and Bowel Protocol 2 was initiated on Day 7.

Episode #3
• April 25, 2015—documentation of last BM (day)
• May 1, 2014— hard stool felt in rectum, glycerin suppository inserted (Bowel Protocol 2)
• May 2, 2014—Resident refused glycerin suppository and enema, said would take a laxative later in the day
• May 3, 2014—glycerin suppository inserted (Bowel Protocol 2)
• May 4, 2014 at 06:20—Fleet enema administered (Bowel protocol 3)
• May 4, 2014 at 11:53—BM

As such on Episode #3, Bowel Protocol 1 was never initiated, and Bowel Protocol 2 was initiated on Day 6.

Episode #4

• May 13, 2014 –documentation of last BM (evening)
• May 18, 2014—Hard stool ++ felt in rectum; glycerin suppository inserted (Bowel Protocol 2)
• May 20, 2014—BM

As such on Episode #4, Bowel Protocol 1 was never initiated, and Bowel Protocol 2 was initiated on Day 5. [s. 131. (2)]

Issued on this 23rd day of July, 2014

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