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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 2018	2018_683126_0015	003974-18	Complaint

Licensee/Titulaire de permis

Bruyère Continuing Care Inc.
43 Bruyère Street OTTAWA ON K1N 5C8

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

Residence Saint-Louis
879 Chemin Parc Hiawatha OTTAWA ON K1C 2Z6

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

LINDA HARKINS (126)

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 30, 31 and August 1, 2018

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, one Registered Nurse and the resident's Substitute Decision Maker (SDM).

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

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

- **4 WN(s)**
- **3 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. (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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to 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 the resident's care needs change.

As per progress notes of a specific date the following assessments were documented:

•At 1535 hours, Registered Practical Nurse (RPN) #107 assessed resident #001 and documented that the pulse was below baseline and was unable to measure the blood pressure when taken. At that time, RPN #107 notified Registered Nurse (RN) #106. Resident #001 was assessed by RN #106 at 16:00.

•At 1910 hours, RN #106 assessed resident #001 and documented that resident #001 was not receiving oxygen and was feeling cold. The oxygen tubing was changed. Resident #001's vital signs and oxygen saturation were taken.

•At 2000 hours, RN #106 assessed resident #001 and documented that resident #001 had difficulty breathing. RN #106 was unable to measure the blood pressure when taken. Resident #001 refused to go to hospital. One hour later, resident #001 was found in the bath room and indicated was feeling better.

•At 2150 hours, RN #106 contacted resident #001's Substitute Decision Maker (SDM) regarding resident #001's change in condition and refusal to go to the hospital. The SDM arrived on site 40 minutes later. The physician was contacted and resident #001 was transferred to the hospital around midnight.

As such the licensee as failed to ensure that resident #001 was assessed between 2100 hours and the transfer to hospital, when the resident's care needs change. Resident #001's health care record was reviewed and it was noted that no documentation was found to indicate an assessment was conducted between 2100 hours and the transfer to hospital. [s. 6. (10) (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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change, 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 ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 health care record was reviewed. In the Medication Administration Record (MAR) it was documented that on a specific date , resident #001 was to be administered an antibiotic intraveinously (IV) . On that specific date, the day shift, RN #108 mixed the IV medication in a 2.5 Litres bag instead of a 2 Litres bag. During the evening shift, RN #106 administered the IV medication prepared by RN #108, for a total of 1500 ml, therefore resident #001 did not received the total dose of the IV medication as per prescription. [s. 131. (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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents and adverse reactions were documented , reviewed and analysed.

Resident #001 health care record was reviewed. In the Medication Administration Record (MAR) it was documented that on a specific date, resident #001 was to be administered an antibiotic intraveinously (IV) . On that specific date, the day shift, RN #108 mixed the IV medication in a 2.5 Litres bag instead of a 2 Litres bag. During the evening shift, RN #106 administered the IV medication prepared by RN #108, for a total of 1500 ml, therefore resident #001 did not received the total dose of the IV medication.

Discussion held with Director of Care (DOC) #100, indicated that a medication incident report was not completed for that specific incident.

As such, this medication incident was not documented, reviewed and analyzed. [s. 135. (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 to ensure that all medication incidents and adverse reactions were documented , reviewed and analysed, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Discussion held with Director Of Care (DOC) #100, indicated that care conference are documented in the resident's health care record.

Discussion held with Registered Nurse (RN) # 102, indicated that they cannot recall the care conference for resident #001, but if it was done, it should be documented in the resident's health care record.

Discussion with Unit Clerk (UC) #103 indicated not having any documentation for resident #001's scheduled care conference.

Resident #001's health care record was reviewed and no documentation was found to indicate that the six weeks care conference following the admission and the annual care conference had taken place.

As such, resident #001 did not have a six weeks and an annual care conference while living at Residence St-Louis. [s. 27. (1) (a)]

Issued on this 11th day of December, 2018

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

Original report signed by the inspector.