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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jun 28, 2019	2019_789435_0011	005405-19, 005583-19	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Courtland
4850 Hwy #59 P.O. Box 279 Courtland ON N0J 1E0

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

AMBERLY COWPERTHWAITE (435), MEAGAN MCGREGOR (721)

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 12 - June 13, 2019

The following intakes were completed during this Complaint Inspection:
Log #005405-19 related to care concerns and;
Log #005583-19 / CIS #2826-000007-19, as the intake related to same areas of care concerns

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Regional Director of Operations, Registered Nursing Staff and Health Care Aids. Inspectors also completed record review and observations during the course of the inspection.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. Specifically, the licensee had failed to ensure that the provision of the care set out in the plan of care, were documented.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint on March 7, 2019, through the MOHLTC Infoline outlining concerns related to the care of resident #001.

The MOHLTC received a Critical Incident System (CIS) report also outlining care concerns brought forward to the home related to the care of resident #001.

Review of resident #001's electronic medication administration record (eMAR) over a period of four months identified multiple blank boxes for ordered medications at identified times.

Review of resident #001's Documentation Survey Report over a period of five months identified multiple blank boxes for care tasks that were instructed to be documented and completed every shift.

During an interview with Registered Nurse (RN) #102, when asked when documenting in the eMAR what a blank box meant for a scheduled medication, RN #102 stated that the blank box meant that it had been missed. RN #102 continued to state that it may have been administered but not signed for on the eMAR. When asked if a blank box meant the same for point of care (POC) documentation for care tasks, RN #102 stated yes.

During an interview with Executive Director (ED) #100, Director of Care (DOC) #101 and Regional Director of Operations (RDO) #104, when asked what a blank box meant for a scheduled task in POC documentation, RDO #104 stated that it meant that staff did not document and that there should never be blanks. When asked if it would be the expectation that if a task was completed it would be documented, DOC #101 and RDO #104 stated yes. When asked what a blank box meant in an eMAR for a scheduled medication, RDO #104 stated that staff could have provided the medication, however the documentation was not completed. When asked if it would be expected that medications that were administered be signed for, RDO #104 stated yes, that all would be expected to be signed for.

The licensee had failed to ensure that the provision of care set out in the plan of care for medication administration over a four month period on multiple occasion, and care tasks over a five month period on multiple occasions, was documented for resident #001.

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 provision of the care set out in the plan of care are documented, 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint through the MOHLTC Infoline outlining concerns related to the care of resident #001.

The MOHLTC received Critical Incident System (CIS) report also outlining care concerns brought forward by the complainant to the home related to the care of resident #001.

During a telephone interview with the complainant, they stated that they had concerns related to staff requesting them to administer medications to resident #001. The complainant continued to state, in part, that they were not trained to give medications to resident #001.

Review of resident #001's progress notes, documented a note on an identified date stating in part, that resident #001 was given an identified medication by the complainant.

Review of another progress note on an identified date documented that resident #001 "Did take [their] meds crushed, administered by [complainant]."

During an interview with Registered Nurse (RN) #102 when asked who administers medications in the home to residents, RN #102 stated that RN's and Registered Practical Nurses (RPN) administer medications to residents. When asked if there would be any circumstance in which someone other than the registered staff in the home would administer a resident their ordered medications, RN#102 stated no. RN #102 continued to state, in part, that unless a resident had been assessed and was able to self-administer their medications, registered staff administer medications. When asked if resident #001 was always administered their medications by a registered staff member, RN #102 stated "always RPN or RN". When asked if RN #102 would expect that resident #001 be administered their medications by the complainant, RN #102 stated no.

During an interview with Executive Director (ED) #100, Director of Care (DOC) #101 and Regional Director of Operations (RDO) #104, when asked who administered medications to residents in the home, DOC #101 stated registered staff. When asked if there would be any circumstance where the registered staff would not be the person to administer a resident their medications, DOC #101 stated no. When asked if they would expect someone other than the registered staff to administer a resident their medications ED #100 stated no and that they would not expect that. Inspector requested ED #100, DOC #101 and RDO #104 to look at the identified progress notes. RDO #104 stated that the nurse had poured the medication for resident #001 and had the complainant give the medication with the nurse standing there. RDO #104 continued to state that it was not normal practice. When asked if there would be documentation that the staff member watched the complainant administer the resident their ordered medications, using the rights of medication administration, RDO #104 stated that it would be documented in the Medication Administration Record (MAR). When asked who administered the resident their medications, DOC #101 stated that the complainant gave the resident their medications. RDO #104 continued and stated that while the nurse did not administer the resident their medications, although not documented in the progress note, they did watch it being given by the family member. RDO #104 stated that the progress note did document that the medication was administered by the family member.

Review of resident #001's eMAR for the identified medications were documented that resident #001 was administered their ordered medications by the registered staff member's electronic signature.

The licensee had failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse when resident #001 was administered their ordered medications by the complainant on identified dates.

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 no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse, to be implemented voluntarily.

Issued on this 2nd day of July, 2019

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

Original report signed by the inspector.