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
Jan 24, 2013	2013_029134_0001	O-000001-13	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

GARRY J. ARMSTRONG HOME
200 ISLAND LODGE ROAD, OTTAWA, ON, K1N-5M2

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): Janaury 11, 15 and 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of care, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), Resident #001 and a Substitute Decision Maker (SDM)

During the course of the inspection, the inspector(s) reviewed Resident #001's Health Records, two Hospital Discharge Reports, the Pain Management Program, the Bowel Management Program - Policy #355:13 and the Medical Directives - Policy # 600:09 .

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Pain

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 failed to comply with the LTCHA section 6 (1)(c), in that it failed to provide clear directions to staff who provide direct care to Resident #001 as it relates to pain management.

On a specific day in September, 2012 there is a chart entry indicating Resident #001 complained of back pain and stated that it was due to sneezing and coughing. There is a second entry made three days later when Resident #001 reported to the physiotherapist that the back pain was due to coughing and sneezing. Three days afterwards, there is an entry indicating Resident #001 complained of right post lower rib cage, possibly due to sneezing and coughing.

In October 2012, Resident #001 complained of right hip pain. The hip pain persisted daily for thirteen days until the resident was transferred to hospital in November, 2012 for assessment.

The Resident's plan of care and the daily Resident Assignment sheet were reviewed and there are no clear directions for staff providing direct care to Resident #001 as to which interventions are to be used to alleviate the Resident's pain and discomfort to back and hip other than prescribed drugs.

The Licensee has a Pain Management Program, dated April 19, 2012, which specifies the following: Residents whose pain is not relieved by initial interventions will receive a full assessment using the pain assessment tool. Furthermore it indicates that 100% of the residents who have identified pain verbally will have an individualized plan of care with treatments, interventions and referrals based on their needs, choice, condition and goals. The policy also provides a list of intervention options to manage pain.

The Pain Assessment tool for Resident #001 was reviewed. The form was initiated on a specific day in November, 2012 and was only partially completed.

As such the plan of care did not provide clear directions to staff providing direct care, as it relates to pain management interventions for Resident #001. [s. 6. (1) (c)]

2. The Licensee failed to comply with the LTCHA section 6 (10)(b)(c) in that Resident #001 was not reassessed when the resident's care needs changed and the plan of care was not reviewed and revised when the care set out in the plan was not effective.

The progress notes of December, 2012 were reviewed. There are several entries indicating Resident #001's condition had dramatically changed within a six day period which included: shortness of breath, weakness and fatigue, laboured respiration, edema in lower one arm and under one eye, pain in lower back, low blood pressure 100/50, rapid pulse 114, respiration 16 and resident required oxygen. Resident #001 had poor appetite, jerking type movements at rest, unable to hold anything in both hands, unable to feed self, talked of dying, had confusion, hand twitching, slurred speech, was slouching in wheelchair, was unable to form coherent sentences, had pain to the stomach and legs, had redness to an arm, blister under one eye, was difficult to arouse, did not have any effects from the bowel treatments, was 6 days without a bowel movement, refused medications and refused to go to hospital.

The charge nurse who was on duty on a specified day in December, 2012, was interviewed and indicated the attending physician was notified of the edema in the resident's arm and no new orders were given at the time. The resident's condition continued to deteriorate over the next six shifts. The physician was not called and the resident was not sent to hospital for further assessment following the progression of the above mentioned symptoms. [s. 6. (10) (b)]

3. There are two entries in the progress notes indicating Resident #001 did not have any results following the laxatives administered on two consecutive days in December 2012. The monthly flow sheet was reviewed. It is clearly documented that Resident #001 had no bowel movement for 6 days. According to the Medication Administration Record Sheet (MARS) there is a doctor's order in December, 2012 that reads: "make sure resident does not go beyond 3 days without a bowel movement". This was not reported to the physician as per the doctor's orders and the Bowel Protocol/Policy & Procedure #355.13, dated August 2012. This policy requires the following: "on day 3, Milk of Magnesia 30 cc to be given at bedtime, on day 4, if no bowel movement to give a glycerine suppository, on day 5, to do a rectal examination, assess bowel sounds and give a fleet enema. If no result to refer to the physician. Resident #001 had an order for Sodium Phophate if no BM for 3 days; this was administered with no results. There are no documented follow-up in the progress notes as whether Milk of Magnesia 30 ml was given as per the bowel protocol.

Charge Nurse (S103), who was on duty on a specified day in December, 2012, was interviewed and indicated that the resident's swollen arm was oozing clear fluid.

Arrangements were made to transfer the resident to hospital for assessment.

PSW (S104), who was assigned to the resident on a specified day in December, 2012, was interviewed. The PSW indicated Resident #001 was very weak during morning care. PSW indicated Resident # 001 was unable to bare weight or use equipment as usual. The PSW indicated the resident's change in condition was not reported immediately to the RPN on duty.

The Licensee failed to review and revise the plan of care when Resident #001's care needs changed and when the care set out in the plan was not effective. As a result, the resident was transferred to hospital. [s. 6. (10) (c)]

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 their plan of care reviewed and revised when the residents' care needs change and the care set out in the plan is not effective; and to ensure that the plan of care provides clear directions to staff who provides direct care to residents as it relates to bowel and pain management, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The Licensee has failed to comply with the O. Reg 79/10 section 134 (a) in that Resident 001's response and effectiveness to taking a combination of the drugs, were not monitored and documented.

The progress notes between August and November, 2012 were reviewed. There are several entries where Resident #001 was administered cough syrup as per the medical directives. The resident's response and the effectiveness of the medication was not documented on six occasions.

Resident #001 was ordered and administered four (4) different controlled substances in 16 days, during November and December 2012. The resident's response and the effectiveness of the medication was not documented.

As such Resident #001 was administered a combination of drugs where the resident's response and effectiveness of the drug was not monitored and documented as per legislative requirement. [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs, in particular when residents are administered multiple controlled substances, appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The Licensee failed to comply with the O. Reg 79/10 section 40, in that it failed to ensure Resident #001 was dressed appropriately and suitable to the time of day.

On January 11, 2013, Inspector #134 visited Resident #001 at 14:30. The resident was wearing trousers that were not done up properly. The resident's abdomen and incontinent brief were exposed.

On January 16, 2013, the inspector visited Resident #001 at 11:10. The resident was still wearing pyjamas and the bottoms were inside out. The resident's SDM was visiting at lunch time and indicated it was unusual to see the resident in pyjamas at that time of day.

PSW S101, who was assigned to resident #001, was interviewed and indicated Resident #001, had refused to get dressed that morning. The PSW indicated the resident was not encouraged to get dressed at a later time and the resident's refusal to get dress was not reported to the charge nurse. [s. 40.]

Issued on this 24th day of January, 2013

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

Colette Cassin, LTCH Inspector #134