Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Mar 10, 2020	2020_763116_0008	002873-20	Complaint

Licensee/Titulaire de permis

Bethany Lodge
23 Second Street MARKHAM ON L3R 2C2

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

Bethany Lodge
23 Second Street MARKHAM ON L3R 2C2

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

SARAN DANIEL-DODD (116)

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): February 24, 25, 26, 27 & March 2, 3, 2020.

During this inspection, a complaint related to continence care, bowel management, medication administration and complaint reporting had been inspected.

During the course of the inspection, the inspector(s) spoke with the Executive Director (E.D.), Director of Care (DOC), Associate Director(s) of Care (ADOC), registered staff (RNs & RPNs), registered dietitian (RD), personal support workers (PSWs), residents and the substitute decision makers (SDMs) of resident #001.

During the inspection, the inspector conducted observations of staff and resident interactions, reviewed relevant clinical health records, staff records, staffing schedules, home's complaint and critical incident system investigation records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Nutrition and Hydration
Reporting and Complaints

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 revised at any other time when, the resident's care needs have changed.

As a result of identifying non-compliance for resident #001, the sample size was expanded to include resident #003 with a similar condition.

Review of resident #003's written plan of care under a required care area documents the resident exhibits a specific status and defined pattern.

Resident #003's clinical records including progress notes, and current required assessments were reviewed and identified the resident as exhibiting a different status and pattern. This change would be considered as irregular.

In separate interviews with PSW #114 and RPN #104 it was found that they were aware of the resident's current pattern and status and the requirement for the written plan of care to be revised.

In an interview, the DOC was made aware of the resident's current pattern, reviewed the resident's clinical record and acknowledged that the written plan of care was not revised once the resident's care needs changed. [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 the resident is reassessed and the plan of care revised at any other time when, the resident's care needs have changed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; and any response made in turn by the complainant.

A complaint was received by the Ministry of Long Term Care (MLTC) whereby the complainant expressed concerns regarding the care of resident #001.

A review of written communication from the complainant to respective members of the management team validated the complainant submitted a written concern regarding care issues.

A review of the home's complaint log failed to support that the concerns identified regarding resident #001 were documented.

In interviews with members of management, it was acknowledged that the complaint log did not contain the required information in accordance with the legislation and confirmed the expectation that the documented record in the home should include all the required information.

The licensee failed to ensure that a documented record is kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any every date on which any response was provided to the complainant and a description of the response, and any response made by the complainant, for the complaints they received from resident #001. [s. 101. (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 a documented record was kept in the home that includes, the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; and any response made in turn by the complainant, to be implemented voluntarily.

WN #3: 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.

A complaint was received by the Ministry of Long-Term Care (MLTC) regarding care issues for resident #001.

Interview with resident #001's SDM indicated that they visited with resident #001 and noted concerns. They had a discussion with the physician regarding the resident's current health status regarding specific care areas.

Review of physician order for resident #001 directed staff to administer a medication once daily over a period of three consecutive days.

Record review of resident #001's electronic medication administration record (MAR) and documentation in the progress notes revealed the medication was not administered over the required treatment period, as per the physician's orders.

During separate interviews with RPN #'s 104 & RPN #105 it was acknowledged that the medication was not available in the home and attempts to locate the treatment were unsuccessful over the required treatment period.

Interviews held with ADOC #102 and DOC #101 acknowledged that the medication was not available for administration during the prescribed treatment period.

In conclusion, the prescribed medication was not administered to resident #001 in accordance with the directions for use specified by the prescriber. [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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any written complaint concerning care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A complainant forwarded a written correspondence of concerns to the attention of the members of the home's management team outlining concerns regarding care issues of resident #001 and operations of the home.

In separate interviews with members of the management team it was communicated that the home's expectation is to forward any written complaint about the care of a resident or the operation of the home to the Director; and further acknowledged that the complaint was not forwarded to the Director.

The licensee has failed to ensure that when a written complaint was received concerning the care of a resident or the operation of the long-term care home, that complaint should immediately be forwarded to the Director. [s. 22. (1)]

Issued on this 11th day of March, 2020

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

Original report signed by the inspector.