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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_798738_0023	029986-18, 013917-19, 013919-19, 013926-19, 013930-19, 013932-19, 013933-19, 020798-19, 021316-19	Follow up

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

AMANDA OWEN (738), MARIA MCGILL (728), TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 25-29, 2019 and December 2, 2019.

The following intakes were completed in this Follow up inspection:

- Log #029986-18 related to compliance order (CO) #003 from inspection #2018_580568_0016 and emergency plans;
- Log #013917-19 related to CO #009 from inspection #2019_610633_0005 and authorization for admission to a home;
- Log #013919-19 related to CO #001 from inspection #2019_610633_0005 and 24 hour nursing care;
- Log #013926-19 related to CO #015 from inspection #2019_610633_0005 and requirements on licensee before discharging a resident;
- Log #013930-19 and CO #016 from inspection #2019_610633_0005 and administration of drugs;
- Log #013932-19 related to CO #018 from inspection #2019_610633_0005 and training; and
- Log #013933-19 related to CO #004 from inspection #2019_610633_0005 and polices to be followed.

The following Critical Incident System (CIS) intakes were also completed during this Follow up inspection:

- Log #020798-19/CIS #M507-000054-19 related to a missing controlled substance; and
- Log #021316-19/CIS #CI M507-000056-19 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Consultants, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The inspector(s) also toured resident home areas, observed resident care provision, resident to staff interaction, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection and interviewed staff and residents.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Falls Prevention
Medication
Quality Improvement
Safe and Secure Home
Sufficient Staffing
Training and Orientation

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

2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 148. (2)	CO #015	2019_610633_0005	728
O.Reg 79/10 s. 230. (7)	CO #003	2018_580568_0016	738
LTCHA, 2007 S.O. 2007, c.8 s. 44. (7)	CO #009	2019_610633_0005	754
LTCHA, 2007 S.O. 2007, c.8 s. 76. (2)	CO #018	2019_610633_0005	728
O.Reg 79/10 s. 8. (1)	CO #004	2019_610633_0005	728
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2019_610633_0005	754

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 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 were administered to residents in

accordance with the directions for use specified by the prescriber.

The following was completed as a Follow up to Compliance Order (CO) #016 from inspection #2019_610633_0005.

A) Resident #045's Medication Administration Audit Report, dated November 2019, showed that a medication was administered late and not as prescribed on seven occasions. The resident was documented to be in pain twice during that time.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #118 acknowledged that the identified medication was administered late and not as prescribed. They were concerned about the resident being in pain during that time.

B) A review of resident #042's Medication Administration Audit Report, dated November 2019, showed that several medications were administered late and not as prescribed on 21 occasions.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #108 and #121 acknowledged that the identified medications were administered late and not as prescribed.

C) A review of resident #059's Medication Administration Audit Report, dated November 2019, showed that a medication was administered late and not as prescribed on 18 occasions.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #108, #119 and #121 stated that specified medication should have been given according to its scheduled time.

The licensee has failed to ensure that drugs were administered to residents #042, #045, and #059, in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the Long Term Care Homes Act (LTCHA), in that they did not comply with every order made under this Act.

The following was completed as a Follow up to CO #018 from inspection number 2019_610633_0005.

Specifically, the licensee must ensure that:

A) That all registered staff receive orientation per the home's orientation process.
B) That all registered staff receive education related to palliative care and the home's related processes including palliative care orders. Annual education is provided thereafter.
C) That all registered staff and the wound care lead receive education related to skin and wound including assessment.
D) That the skin and wound education is developed according to best practices and in consultation with a Wound Care Specialist.
E) That all direct care staff receive education related to falls prevention and management including assessment.
F) That a written record is kept of the education that includes who completed the training, the content, and date staff sign off.

The compliance due date was October 25, 2019.

The licensee completed part A, C, D, E, F of CO #018. The licensee did not complete part B of the CO.

Review of the palliative care education provided in the home identified that the education did not include the home’s process for palliative care orders.

RPN #104 and RN #106 said they received palliative care education; however, the education did not include the home’s processes related to palliative care orders.

RN #106 and RPN #108 said staff had received conflicting direction from management related to implementing palliative orders.

RN #106 said new staff, in particular, were conflicted as to the criteria for deeming a resident palliative and at times residents have had palliative orders signed when they were not yet palliative.

DOC #111 and RN Consultant (PrimaCare) #103 said that the PowerPoint and palliative policy did not provide staff with education on the home’s process for palliative orders.

The licensee failed to ensure that education was provided to all registered staff on the process for palliative care orders in the home as directed by CO #018. [s. 101. (3)]

Issued on this 19th day of December, 2019

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA OWEN (738), MARIA MCGILL (728), TAWNIE URBANSKI (754)
Inspection No. / No de l'inspection :	2019_798738_0023
Log No. / No de registre :	029986-18, 013917-19, 013919-19, 013926-19, 013930-19, 013932-19, 013933-19, 020798-19, 021316-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 19, 2019
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Griffin Allen

To Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_610633_0005, CO #016;

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 131. (2) of the Long Term Care Homes Act (LTCHA).

Specifically the licensee must ensure:

a) Drugs are administered to residents #042, #045, #059 and all other residents, in accordance with the directions for use specified by the prescriber.

b) All registered staff receive education related to best practices for administering time sensitive medications. A written record is kept of the education that includes who completed the training, the content and date staff sign off.

c) The implemented auditing process related to medication administration includes residents that are receiving time sensitive and high alert medications.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The following was completed as a Follow up to Compliance Order (CO) #016 from inspection #2019_610633_0005.

A) Resident #045’s Medication Administration Audit Report, dated November 2019, showed that a medication was administered late and not as prescribed on

seven occasions. The resident was documented to be in pain twice during that time.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #118 acknowledged that the identified medication was administered late and not as prescribed. They were concerned about the resident being in pain during that time.

B) A review of resident #042's Medication Administration Audit Report, dated November 2019, showed that several medications were administered late and not as prescribed on 21 occasions.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #108 and #121 acknowledged that the identified medications were administered late and not as prescribed.

C) A review of resident #059's Medication Administration Audit Report, dated November 2019, showed that a medication was administered late and not as prescribed on 18 occasions.

Progress notes and the eMAR were reviewed and failed to identify a rationale for the identified medication being administered late and not as prescribed.

RPN #108, #119 and #121 stated that specified medication should have been given according to its scheduled time.

The licensee has failed to ensure that drugs were administered to residents #042, #045, and #059, in accordance with the directions for use specified by the prescriber.

The severity of this issue was determined to be a level two as there was minimal harm/minimal risk of harm to the residents. The scope of the issue was a level three as it related to three of three residents reviewed. The home had a level five

history as they had on-going non-compliance with this section of the LTCHA and four or more compliance orders that included:

- Compliance Order (CO) #016 issued June 11, 2019 with a compliance due date of October 25, 2019 (2019_610633_0005); and
- Written Notification (WN) issued November 12, 2019 (2019_800532_0013).
(738)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 10, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 19th day of December, 2019

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amanda Owen

Service Area Office / Bureau régional de services : Central West Service Area Office