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
Jan 18, 2019	2019_603194_0001	021856-17, 023239-17, 027156-17, 003561-18, 007271-18, 012798-18, 014865-18, 018859-18, 025401-18, 032248-18	Critical Incident System

Licensee/Titulaire de permis

0760444 B.C. Ltd. as General Partner on behalf of Omni Health Care Limited Partnership

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

Burnbrae Gardens Long Term Care Residence
320 6th Line East CAMPBELLFORD ON K0L 1L0

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

CHANTAL LAFRENIERE (194)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 2, 3, 4, 7, 8, 9 and 10, 2019

This inspection included Log #032248-18, Log #012798-18 and Log #025401-18, for fall of residents; Log #014865-18, Log #027156-17, for allegations of resident to resident abuse; Log #007271-18, Log #018859-18, for allegations of staff to resident abuse; Log #021856-18, for allegations abuse; Log #023239-17, and Log #003561-18, for unaccounted controlled substances.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (ADOC), RAI co ordinator, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Residents.

The inspector reviewed applicable policies, identified resident's clinical health records, documentation related to storage and management of controlled substances, internal abuse investigation records and staffing educational records. The inspector observed the interactions between identified residents and the provision of staff to resident care.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance will all applicable requirement under the act.

Under O. Reg. 79/10 s. 114 (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents

Review of "PRN Administration and Documentation" Policy 8-4 dated February 2017 indicated;
-Document administration on Medication Administration Record (MAR) sheet including
-time of administration
-actual dose given for orders with dosage ranges
-initial correct date column
-Document nursing assessment and follow up on progress notes, facility RPN administration Record or on reverse side of the MAR sheet, according to the facility's practice. Documentation to include:
-date, time, medication, dose, reason (as applicable to physician's order) medication was given nurse's initials.
- effect, nurse's initials.

Review of "Medication Incident Reporting" Policy 9-1 dated February 2017 indicated: Definition – Medication Incident: Any preventable event that may cause or lead to inappropriate medication use or client harm while the medication is in the control of the health care professional. Such events may be related to professional practice, health care products, procedures and systems, including prescribing: order communication:

product labelling: packaging and nomenclature: compounding: dispensing; distribution: administration; education; monitoring and use.
- Complete the Medical Pharmacies "Medication Incident Report" on line.
- All medication incidents are reviewed by the home "interdisciplinary team" including the Administrator, the Director of Care, the Medical Director or prescriber and the Clinical Consultant Pharmacist. Changes and improvements identified in the review are to be implemented and a written record kept on file at the home.

Related to Log # 003561-18

Review of the clinical health records for resident #011 for the period of one month, related to administration of a controlled substance, by RN #111 was completed by Inspector #194.

The Physician Orders for resident #011 indicated that RN #111 received a telephone order by physician, on an identified date, for a controlled substance. Review of the Shift Change Monitored Medication Count was completed for an identified month, indicated that a specific amount of the controlled substance was taken and co-signed by RN #111. RN #111 reported to RAI co-ordinator during a previous telephone interview that the specific amount of the controlled substance had been removed from the Emergency Stock Box on the identified date. RAI coordinator indicated to Inspector #194 that during the telephone interview with RN #111, the RN had indicated it had been a very busy shift and that the medication administration of the controlled substance had been documented on the physicians order. Review of the physician order was completed by Inspector #194, it was noted that the RN #111 had documented the administration of a number of separate doses of the controlled substance.

RN #111 and DOC were not available for interviews during inspection period.

Review of the progress notes and MARS for the identified month, for resident #011 was completed by Inspector #194. RN #111 did not have any documentation to support that the controlled substance was administered, or the effect of the medication for resident #011.

During interview with Inspector #194, the Administrator indicated that the home was unable to locate any medication incident record related to the incident involving RN #111 and administration of controlled substance to resident #011 on the identified date.

The licensee failed to comply with its medication policies; PRN Administration and Documentation and Medication Incident Reporting on an identified date. RN #111 did not document the administration or effect of the controlled substance to resident #011 as per policy and licensee did not initiate a medication incident report for RN #111 when it was informed of the incident as per policy. [s. 8. (1) (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 by ensuring that the licensee's; PRN Administration and Documentation and Medication Incident Reporting policies are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to protect resident #015 from neglect on an identified date, when PSW #115, #116 and #108 failed to provide the resident with specific personal care.

O. Reg. 79/10 Definition of Neglect means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Log #018859-18

During review of the home's internal investigation for CIR into the allegations abuse/neglect towards resident #015, Inspector #194 reviewed the statements of PSW

#115, #108, #116 and #117 as well as RN #118 related to the events on the identified date. The outcome of the home's internal investigation indicated that the allegations of neglect of care to resident #015 were founded.

Review of the plan of care for resident #015 related to specific care was completed by Inspector #194. The plan of care for resident #015 at the time of the incident indicated two staff assist with all transfers and ADL, and one staff assist with mobility device.

Interview with resident #015 was conducted by Inspector #194. Resident #015 was unable to recall the incident on identified date, when first asked and then denied the incident later in the interview. Resident #015 was very vague about any specifics related to the provision of care. Resident #015 indicated being able to inform staff when they needed assistance with care and was sometimes told they would need to wait for a few minutes. Resident #015 was unable to state the length of time it took for staff to respond.

A review of the internal investigation and PSW's #115's statement indicated, resident #015 pulled call bell for assistance with care, PSW #115 indicated they explained to resident that it would take some time before they could get to the resident as they were alone on the unit. PSW #115 indicated in investigation statement that when the partner returned from break they provided care for resident #015. PSW #115 had later been asked by RN #118 to assist resident #015 with specific care at the residents' request. The reviewed statement indicated resident #015 was not assisted with the specific care, by PSW #115.

During interview with inspector #194, PSW #108 indicated that they reported the abuse to the Charge RN. PSW #108 indicated working with PSW #115. PSW #108 indicated that resident #015 was observed to be crying. PSW #108 asked the resident what was wrong and was told that PSW #115 made resident #015 wait 45 minutes for assistance with care. PSW #108 indicated observing resident #015 sitting in common area while providing care to a co-resident, but did not assist resident #015 with care. PSW #108 indicated that resident #015 was a one staff assist with ADL's and that PSW #115 was responsible for resident #015's care. PSW #108 indicated being present, later when, RN #118 asked PSW #115 to assist resident #015 with specific care and PSW #115 refused. PSW#108 indicated that they did not assist resident #015 with specific care, after PSW #115 refused because they had documentation to finish.

Review of PSW #116's internal statement, involving resident #015 related to care indicated, that PSW #115 assisted resident #015, to the common area at a specific time.

PSW #116 was completing the co-resident's care an hour later, when PSW #115 and #116 assisted resident #015 with care. Review of PSW #116 statement indicated that PSW #115 refused to assist resident #015 with specific care and the resident was taken back to their room .

Resident #015 was noted to have been assisted with specific care, by the following shift as per the RN #118 statement.

PSW #115 and #116 and RN #118 were not available for interview during the inspection period.

Interview with Administrator was conducted by Inspector #194, related to the outcome of the home's internal investigation. Administrator indicated to Inspector #194 that resident #015's specific care, was not provided by PSW #115 and #108.

The licensee failed protect resident #015 from neglect specific care was not provided by PSW #115, #116 and #108 when requested by the resident. [s. 19. (1)]

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 by ensuring that residents are protected from neglect by staff at the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the neglect investigation were reported to the Director related to the allegations of neglect of resident #001.

A CIR reporting the allegations of neglect to resident #001, were submitted to the Director following after hours being informed of the allegations. The CIR indicated that resident #001 had been found by SDM, with transfer device blocking resident's mobility aide and call bell not in reach.

During interview with Inspector #194, Administrator verified that the CIR had not been amended and that the Director had not been informed of the outcome of the neglect investigation involving resident #001. Administrator indicated that the outcome of the homes internal investigation concluded that neglect to resident #001 was unfounded. [s. 23. (2)]

Issued on this 18th day of January, 2019

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

Original report signed by the inspector.