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
Mar 22, 2019	2019_583117_0017	023450-18	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 Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

LYNE DUCHESNE (117)

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): March 11, 12, 13, 14 and 18, 2019

This inspection relates to a complaint regarding resident care and services, resident-staff communication and response systems, medication management systems, responsive behaviours, skin and wound care, as well as staffing.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care, a Physician, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), the RAI Coordinator as well as a member of the housekeeping staff.

During the course of the inspection, the inspector reviewed several resident health care records, observed the provision of resident care and services, observed medication administration passes, ob served use and functionality of medical equipment supplies, observed resident rooms and resident-staff communication and response system, observed resident common areas, reviewed the policy # 4-009 related to Medication Systems: ISMP List of High Alert Medications in LTC Setting, the procedure related to Management of Hypoglycemia, dated November 2018, reviewed the home's staffing schedule for August 2018, reviewed the BRAUN ThermoScan Pro 600 Ear Thermometer Directions for Use.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

2 WN(s)
1 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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #001 had diabetes and receives insulin twice daily based on blood sugar values. If resident blood sugar values are lower than a prescribed value (mmol/L), the resident is not to receive any insulin.

On a specified day in 2018, resident #001's morning blood sugar values were below normal values. Insulin was not administered as per medical orders. The resident had a full breakfast and their blood sugar was retested 2 hours later. Chart documentation indicates that the blood sugar values were below normal values. The resident did eat half of their lunch. The resident's blood sugar was tested prior the evening meal and noted to be within normal values. The evening RPN #117, documented that the resident was alert and expressed no concerns. There is no documented information related to the resident's general health status when the blood sugar values were below normal values.

Five days later, resident #001's morning blood sugar values were below normal values. The resident was noted to have a full breakfast. The resident's blood sugar values were retested approximately 2 hours later and noted to have increased. The RN #110 documented that resident had expressed having pain to an identified area that morning and had received a medication with effect. Progress notes indicate that the resident's family visited and the resident expressed no concerns.

Four days later, resident #001's morning blood sugar values were below normal values. Insulin was not administered as per medical orders. The resident received apple juice

and ate half of their breakfast meal. The blood sugar was retested 30 minutes later. Chart documentation indicates that the blood sugar values were below normal values. The resident did eat three quarters of their lunch. The resident's blood sugar was tested prior the evening meal and noted to have increased. Reviewed progress note, from day RN #118 indicates that the resident needed feeding assistance, and was noted to be sleeping at meal time. The resident was also noted to have had trouble swallowing. There is no documented information related to the resident's general health status and associated reassessments when the resident's blood sugar values were below normal values.

A review of the resident's health care record indicates that the resident was seen by the attending physician on a specified day, one day prior to the above incident. No changes were made to the resident's diabetic medication.

The next day, the resident's blood sugar values were below normal values and the resident ate a full breakfast and a full lunch. There is no documentation indicating that the resident's blood sugar was reassessed or documentation related to the resident's general health status in the morning. It is noted that the attending physician was contacted and informed that this was the 3rd episode of the resident presenting with low blood sugar levels in one week. The physician changed the resident's insulin order and decreased by half the amount to be administered twice daily.

RPNs #108 and #117, RNs #110 and #118 as well PSWs #106, #107, #112, #113 and #114 said that the resident in general was alert, ate well most of their meals and did not voice any concerns regarding their health status during this 10 day period. The resident did not present with any signs and symptoms of low blood sugar. If the resident was feeling unwell, PSW staff would have reported the changes to the resident's health status to the registered nursing staff who would then assess the resident. As per RPNs #108 and #117, RNs #110 and #118, when a resident presents with blood sugar levels below normal values, nursing staff are to give the resident juice or food and assess their general health status. Approximately 15 to 30 minutes later, nursing staff are to retest the resident's blood sugar levels. If the blood sugar levels are still low, they are to give more juice and food and retest again within 15-30 minutes. If the resident is presenting with signs and symptoms of having low blood sugar values, nursing staff are to notify the resident's attending physician. RPNs #108 and #117, RNs #110 and #118 said that the blood sugar and health status assessments of residents presenting with blood sugar levels below normal values are to be documented in the resident's health care record.

The home's DOC and Administrator said that the nursing staff are to document all of their assessments, reassessments and interventions as well as the resident's response to these in the resident's health care records. This includes the assessments, reassessment and interventions related to low blood sugar levels. [s. 30. (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 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment and devices in the home in accordance with manufacturers' instructions.

On a specified day in 2018, resident #001 was assessed by RN # 119 as being hot to the touch. The RN documented in the resident's health care record that the home's two thermometers were not functioning and could not assess the resident's body temperature. Medication were. Approximately 3 hours later, the resident was re-assessed by RN # 120 who documented the resident's temperature as being within normal values. It is noted that the resident's temperature had been taken the two previous days, with no identified issues with the thermometer. Resident #001's temperatures on those days were within normal values.

Discussion was held with the home's DOC regarding the functionality of the home's thermometers. The DOC said that the home uses BRAUN ThermoScan PRO 600 ear thermometers. The thermometers do work but need to be recharged on a regular basis as well as need to have the batteries changed on a regular basis to ensure their functionality. When RN #119 reported that the thermometers were not functioning, the DOC changed the batteries in both thermometers. The thermometers were then functional and resident #001's temperature was reassessed by RN #120. The DOC said that spare batteries are kept in the home's second floor medication room. RNs # 109, #110 #118, and RPN #108, confirmed that if the BRAUN thermometers were not functioning well, they would verify and change the batteries. All said that spare batteries are kept in the second floor medication room.

As per the BRAUN manufacturer's instructions for the BRAUN ThermoScan PRO 600 ear thermometers, if the thermometer is presenting with error messages and notifications, the user is to change probe covers and reset the thermometer. If errors message and notifications are still present, the user is to remove the batteries and reinsert them, or if the batteries are dead, new batteries are to be inserted.

As such, the manufacturer's instructions were not followed on a specified day in 2018 when the thermometers were noted to be not functioning. [s. 23.]

Issued on this 3rd day of April, 2019

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

Original report signed by the inspector.