Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 24, 25, 30, Feb 2, 2012	2012_024137_0003	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 HARRISTON
24 LOUISE STREET, P.O. BOX 520, HARRISTON, ON, N0G-1Z0

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

MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Director of Care, a Registered Nurse, a Registered Practical Nurse and the Nurse Clerk.

During the course of the inspection, the inspector(s) reviewed resident's clinical records, including MARS, physician's orders, fall assessment, progress notes, plan of care, internal incident report, oxygen therapy assessment, registered staff meeting minutes, Continuous Quality Improvement (CQI) Action Plan and policies related to Falls and Medication Reconciliation.

L-001738-11

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. There is no documented evidence that Oxygen therapy, including how many litres per minute, method or frequency of use, was identified on the plan of care for an identified resident.
[LTHCA, 2007, S.O. 2007, c.8, s.6(1)(a)(b)(c)]
2. A Fall Risk Assessment was completed on the day of admission. An identified resident was assessed as a "moderate risk" for falls, with a score of 15.0.
There was no documented evidence of falls being identified on the plan of care.
[LTHCA, 2007, S.O. 2007, c.8, s.6(1)(a)(b)(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 there is a written plan of care that sets out the planned care, the goals the care is intended to achieve and give clear direction to staff and others who provide direct care to the residebnt, to be implemented voluntarily.

WN #2: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. MEDICATION RECONCILIATION POLICY # 10-8 Medical Pharmacy Manual
The policy indicates that it is a multidisciplinary process lead by the nurse, who creates the Best Possible Medication History (BPMH) with information obtained from the resident, resident's family or responsible party, transferring facility or hospital, CCAC and previous pharmacy.
The nurse is to compare the list of medications against the physician's admission, transfer or discharge orders.
The DOC and Nurse Clerk both confirmed that it is the nurse clerk who transcribes the orders onto the BPMH and not the nurse.
A registered nurse shared that not all registered staff compare the list of medications, against the physician's admission, transfer or discharge orders, before faxing to the physician or before processing.
The Director of Care confirmed that the orders were not checked by the RN or RPN before being faxed to the physician.
[O. Reg. 79/10, 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 to ensure that the home's plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The Director of Care and the Nurse Clerk both confirmed that the Nurse Clerk is responsible for transcribing the physician orders, from the hospital discharge medication plan, onto the home's Best Possible Medication History (BPMH) Reconciliation/Admission Orders form. The home does not have a written policy and protocol developed for this practice.
[O. Reg. 79/10, s.114(3)(a)(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 there are written policies and protocols developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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 home received an identified resident's hospital Medication Discharge Plan, which indicated a medication previously prescribed Three Times Daily As Needed, was to be stopped.
The Nurse Clerk transcribed the medication onto the home's Best Possible Medication History (BPMH) form in error, and indicated it to be given TID (Three Times Daily).
The orders were faxed to the same physician for authorization and signature. The physician signed the form and returned it to the home, on the same day.
The orders were processed by a Registered Nurse and Registered Practical Nurse on the day of admission.
As confirmed by the Director of Care, the orders were not checked by the RN or RPN before being faxed to the physician.
The medication error was not detected by the home until the family brought their concerns forward to the Director of Care.
[O.Reg. 79/10, 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 #5: 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. There is documented evidence in the resident's progress notes, that the family expressed concern on two occasions as to why the resident was receiving an identified medication. The first occasion, the family indicated that the resident is sleepy all the time because of this.
On the second occasion, the family shared that the resident really doesn't need that much during the days and was going to call the physician to review the medications.

There is no documented evidence that the registered staff assessed or monitored the resident's response to the medication or contacted the physician regarding the family's concerns.
[O. Reg. 79/10, 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, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

Issued on this 2nd day of February, 2012

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

Marian C. MacDonald