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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 24, 2019	2019_730593_0015	004564-19	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 Lindsay Nursing Home
240 Mary Street West LINDSAY ON K9V 5K5

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

GILLIAN CHAMBERLIN (593)

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): May 6 - 9, 2019.

Inspector #732 completed a concurrent Critical Incident (CIS) inspection (2019_593573_0012) during this complaint inspection. The following non-compliance was identified by Inspector #732 and is captured in this report:

r. 131. (2) related to CIS log #023817-18- improper/ incompetent treatment of residents related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Nurse Educator, Registered Nursing staff, Personal Support Workers (PSW) and Unit Clerks.

The Inspector observed the provision of care and services to residents, resident's environment, staff to resident interactions, reviewed resident health care records, licensee incident reports and licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Nutrition and Hydration

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care for resident #001 was provided to the resident as specified in the plan.

A complaint was received regarding an incident where resident #001 was provided a regular textured snack by a staff member the day after the resident was ordered a modified texture diet. It was indicated in the complaint that the resident choked, was sent to hospital and passed away soon after.

A review of resident #001's health care records at the time of the incident, found the following:

Documented Care plan: Provide modified texture.
Physicians orders: Modified texture, SP intervention.
Kardex: Provided modified texture.

A review of resident #001's progress notes, found the following:

Day 1- Resident #001 is no longer able to gum food. Texture downgraded. POA informed. Physicians orders, care plan and dietary database updated. Registered Dietitian (RD) #104

Day 2- PSW was assisting resident out of bed to come for lunch, they had refused to get up for breakfast. RPN #103, PSW and student asked resident if they would like to eat and they stated that they would like a snack and a drink. PSW and student got a regular textured snack from the kitchen. Resident took a small bite of the snack and started to choke, student stated that it appeared that resident swallowed some of the snack. When RPN #103 re-entered the room, three PSW's and two student's had the resident sitting up and were encouraging the resident to cough up mucous. RPN #103

Day 2- RN #109 informed by RPN #103 that resident #001 requested a snack and a drink, that RPN #103 instructed PSW/student to provide the resident with what they wanted if they will take it. Mouth suctioned for moderate amount of clear to white phlegm. No deep suctioning done due to being told of choking on snack provided. RN #109 contacted the physician regarding no improvement. Instructed to send to hospital for assessment. RN #109

During an interview with Inspector #593, May 8, 2019, RD #104 indicated that on day 1 they assessed resident #001 and changed the diet texture as the resident was not doing well with food. RD #104 indicated that they updated the diet change in the residents care plan, the kitchen and informed some staff verbally. They added that they should have

written it on the home (communication) page as well, as some shifts do not communicate everything to the next shift. RD #104 indicated that the snack provided should have been texture modified on the prescribed modified texture diet.

During an interview with Inspector #593, May 9, 2019, RPN #103 indicated that they were the charge nurse for B wing day 2 and they had instructed the PSW to get resident #001 up as the resident had missed breakfast and they did not want the resident missing lunch as well. RPN #003 added that the resident was given a specific snack as that is what they had requested. RPN #003 indicated that they were aware that resident #001 had been downgraded to a specific modified textured diet the previous day however had not communicated this to PSW staff on day shift. RPN #103 further indicated that the PSW staff have access to the resident's chart where this dietary texture change had been documented the previous day.

During an interview with Inspector #593, May 9, 2019, DOC #101 indicated that dietary changes should be documented and communicated verbally to the next shift. They added that the RD and Nutrition Manager cannot be at every shift report and it is the responsibility of the nurse to communicate dietary changes at shift report.

Resident #001 was ordered a specific modified texture diet. The following day, resident #001 was provided a snack that was not texture modified. As such, the licensee has failed to ensure that the care for resident #001 was provided to the resident as specified in the plan. [s. 6. (7)]

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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 resident #001 in accordance with the directions for use as specified by the prescriber.

A complaint was received regarding an incident. It was indicated in the complaint that resident #001 missed a dose of medications as the nurse forgot to administer them to the resident.

A review of resident #001's medication administration record (MAR) for February, 2019, found three specific medications ordered. These three medications were documented in the February, 2019 MAR as being administered on a specific day at 2100 hours by RPN #110.

The medication incident report was reviewed: RPN #110 documented that these three specific medications were given at the time but appeared in the resident's medication box the next morning.

During an interview with Inspector #593, May 9, 2019, the Director of Nursing (DON) #101 indicated that RPN #110 did not remove the last strip of medications (containing the three specific medications) to be administered however signed off in the MAR that the medications were administered. [s. 131. (2)]

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

A critical incident report (CIR) was submitted to the Director describing that registered practical nurse (RPN) #126 did not administer, to numerous residents on C wing, their medications for 1700 hours on a specific day.

Resident Care Coordinator (RCC) #103 provided Inspector #732 with all the medication incident reports from this specific day. Inspector #732 confirmed with RCC #103 that

there were twelve medication incident reports and that twelve residents did not receive their medications.

One of the residents identified was resident #007 who was on a high risk medication. Inspector #732 reviewed resident #007's medication incident report and electronic health care record (eMAR). Resident #007 was prescribed a specific medication before dinner, another specific medication at 1630 hours, another at 1659 hours, and a fourth medication at 1700 hours. The medication incident report for resident #007 indicates that the above medications were not administered to resident #007 by RPN #126. Resident #007's eMAR also indicated to administer a specific assessment three times daily; 0730 hours, 1130 hours, and 1630 hours. The medication incident report indicated that RPN #126 did not administer this specific assessment for resident #007 at 1630 hours.

Inspector reviewed resident #005's medication incident report from this specific day and eMAR. Resident #005 was prescribed four specific medications, all at 1700 hours. The medication incident report for resident #005 indicated that the above medications were not administered to resident #005 by RPN #126.

Inspector also reviewed resident #014's medication incident report from this specific day. Resident #014 was prescribed four specific medications, all at 1700 hours. The medication incident report for resident #014 indicated that the above medications were not administered to resident #014 by RPN #126.

In conclusion, the licensee failed to ensure that drugs were administered to twelve residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 4th day of June, 2019

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

Original report signed by the inspector.