Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Oct 29, 2019	2019_664602_0045	018575-19	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 Marmora
58 Bursthall Street P.O. Box 429 MARMORA ON K0K 2M0

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

WENDY BROWN (602)

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): October 22 - 25, 2019

The following log(s) were inspected:
Lg #: 018575-19 - regarding alleged improper care/resident harm.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Nutritional Services Manager, the Resident Care Coordinator, the RAI Coordinator, residents and family members.

In addition, observations of resident care service delivery and reviews of electronic and hard copy health care records, investigation documents, and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 SDM was provided the opportunity to participate fully in the development and implementation of the plan of care for resident #001.

On a specified date, Registered Practical Nurse (RPN) #103 advised inspector #602 that as part of their Doctors Order procedure, the Substitute Decision Maker/ Power of Attorney (SDM/POA) are to be alerted to medications changes/new medication orders . The Director of Care (DOC) #101 confirmed, on October 24, 2019, that the Doctors Order procedure included alerting the the SDM/POA to changes and new medications.

An electronic and hard copy chart review found that resident #001 was started on a new medication on a specified date. A specified number of changes were made to the dose of this medication over a period of time; the SDM/POA was not alerted to the new medication order(s) or any of the subsequent changes..

The licensee did not inform the SDM/POA as to the new medication order or changes to the medication as part of the plan of care. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan:

Resident #001's plan of care indicated they were to have a specified type of care after a specified period of time as outlined in their best practice guidelines reference documents. The practice was confirmed by the: Administrator #100, the Resident Care Coordinator (RCC) #105, the Regional Director /Nurse Educator #106, the DOC #101, an RPN # 103 and the RAI Coordinator #108.

Resident #001 resided in the home for a specified period of time and did not receive the specified care despite best practice guidelines indicating the care should have been provided. [s. 6. (7)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed immediately, in as much detail as is possible in the circumstances, of an unexpected or sudden death.

Resident #001 was admitted to Caressant Care (CC) Marmora Nursing Home with multiple diagnoses. An electronic and hard copy chart review found no indication that any of the diagnoses were "end stage", nor was the resident deemed palliative. Physician goals at admission included maintenance and improvement. Advance directive planning documentation noted resident #001 was a "full code" (allows for all interventions needed to restore breathing or heart functioning including transfer to hospital).

On a specified date resident #001 was taken to hospital via ambulance where they were admitted; the resident subsequently passed away in hospital after a specified period of time. A complaint was made to the Director following resident#001s death regarding alleged improper care/resident harm; the licensee did not inform the Director of resident #001's unexpected death. [s. 107. (1) 2.]

Issued on this 31st day of October, 2019

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

Original report signed by the inspector.