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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 8, 2014	2014_270531_0015	O-000425-14, O-000478-14	Complaint

Licensee/Titulaire de permis

CARVETH NURSING HOME LIMITED
375 JAMES STREET, GANANOQUE, ON, K7G-2Z1

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

CARVETH CARE CENTRE
375 JAMES STREET, GANANOQUE, ON, K7G-2Z1

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

SUSAN DONNAN (531)

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): July 23, and 24, 2014

During the course of the inspection, the inspector(s) spoke with Residents, Residents Family members, Personal Support Workers, Physiotherapy Aides, Director of Care, Associate Director of Care, and a Physician.

During the course of the inspection, the inspector(s) toured the home, reviewed Resident health care records, Laboratory Requisition and Documentation policy and procedure, INR Documentation Record, INR Documentation policy and procedure, Laboratory Requisition Binder, Falls Prevention and Management policy and procedure, falls committee minutes, falls assessment forms including post fall huddle assessments, and restorative care program.

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

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (12) 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 explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licensee has failed to comply with the Long-Term Care Homes Act 2007 , c. 8, s. 6(12) whereby the resident's substitute decision-maker, or any other persons designated by the resident or substitute decision-maker were not given an explanation of the plan of care.

On a specified date Resident #1 was prescribed a new medication to be given as required.
Review of Resident #1 electronic medication administration record confirm that the medication was administered to Resident #1 on nine specified dates.

During an interview with the Director of Care and review of Resident #1 health care record confirm that the new medication had been prescribed and administered as required without the substitute decision-maker being notified or given an explanation. [s. 6. (12)]

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:

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 has failed to comply with O. Reg 79/10 section 8 (1) in that the policy and procedure "INR Documentation" reviewed and was not complied with.

O. Reg. 30 (1) states that every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes.
The "INR Documentation Policy" states there will be a process to document INR's on an ongoing basis to visually assess the resident's INR in one location on the chart.
Procedure #1. The documentation of INR's, for all residents, will be completed on a 1 page format that will allow the physician and registered staff to visually assess the resident's INR on an ongoing basis in 1 place.
#6. Upon receiving INR blood test results, the registered staff will document the date the INR result was received , the actual numerical result, the new or current ongoing anti coagulation dose, the date that the next test is to be completed, full staff signature and professional designation and when the form is completed a fax column verifying that the form was faxed to the physician on the "INR Documentation Record" form.

On a specified date during an interview with the Director of Care , the Assistant Director of Care , and review of the physician letter, and internal communication memos to staff confirm that the INR policy was not complied with. [s. 8. (1)]

WN #3: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3) (4) whereby the licensee failed to report an injury for which the person was taken to hospital to the Director in one business day.

On a specified date Resident #1 fell and sustained an injury requiring transfer to hospital.

On a specified date during an interview with the Director of Care confirm that a Critical Incident report for the injury for which Resident #1 was taken to hospital was not submitted to the Director . [s. 107. (3) 4.]

Issued on this 25th day of August, 2014

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