Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: August 24, 2023	
Inspection Number: 2023-1488-0005	
Inspection Type: Critical Incident	
Licensee: Centre d'Accueil Roger Seguin	
Long Term Care Home and City: Centre d'Accueil Roger Seguin, Clarence Creek	
Lead Inspector Kelly Boisclair-Buffam (000724)	**Inspector Digital Signature** Kelly Boisclair-Buffam Digitally signed by Kelly Boisclair-Buffam Date: 2023.08.28 11:06:52 -04'00'
Additional Inspector(s) Lisa Kluke (000725) Joelle Taillefer (211)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 17, 18, 21, 22, 2023.

The following intake(s) were inspected:

- Intake #00088151 and Intake #00093141 were related to alleged abuse of a resident.
- Intake #00088694 and Intake #00089928 were related to falls prevention and management.
- Intake #00092986 was related to a written complaint to the home regarding an alleged abuse.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' drug regimes

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)

The licensee has failed to ensure that when a resident was taking a pain medication, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Rational and Summary:
On a date in 2023, a resident's Medication Administration Record (MAR) indicated that a controlled substance was administered at a specific time to relieve the resident's pain. The resident's progress notes indicated to assess the resident's pain level, one hour after the administration of the medication. On that date, in the early afternoon, a Registered Nurse (RN) documented in the progress notes that the resident's pain level follow-up was scheduled in the morning, but the actual drug evaluation and the effectiveness was completed in the early afternoon.

The next day, the resident's MAR indicated that a controlled substance was administered at a specific time. The progress notes indicated to assess the resident's pain level four hours and fifty-four minutes later. There was no documentation of any follow-up of the effectiveness of this medication.

The Resident Assessment Instruments and Minimum Data Set (RAI-MDS) Coordinator stated that the homes expectation is that the resident's pain level evaluation and effectiveness should be assessed one hour after the controlled substance was administered.

As the monitoring of the controlled substance was not documented at the time specified in the resident's health care record, there was a risk that the pain evaluation and effectiveness was not accurate.

Sources: Resident's health care records and interviews with the RAI-MDS Coordinator, Director of Care, and the Administrator. [211]

WRITTEN NOTIFICATION: Skin and wound care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)

The licensee has failed to ensure that a resident who is at risk of altered skin integrity, received a skin assessment by a member of the registered nursing staff upon returning from the hospital.

Rational and Summary:
On a date in 2023, a resident sustained an injury after a fall. The resident was sent to the hospital on that date and returned on the following shift. A RN documented that the resident had an altered skin integrity on an identified area of their body.

The RAI-MDS Coordinator indicated that the resident did not receive a skin assessment by a member of the registered nursing staff upon returning from the hospital.

As the resident did not receive a skin assessment upon return from the hospital, there is a risk that altered skin integrity can go unnoticed.

Sources: The resident's health care records and interviews with the Resident Assessment Instruments and Minimum Data Set (RAI-MDS) Coordinator, the Director of Care (DOC) and the Administrator. [211]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs are stored in an area that is secure and locked.

Rationale and Summary:
On a specified date during this inspection, Inspector #000725 observed the a medication dispensary room to be propped open. Inside this dispensary room, there were bottles of government stock medications located on an open shelf and injectable medications inside the refrigerator.

A RN reported the medication door is never left open when unattended and then proceeded to close the door five minutes later.

As such, this door to the medication dispensary was not secure and locked posing potential risk for resident access to medications inside this area.

Sources: Observations and Nursing staff interview. [000725]

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