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

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

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347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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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
Jul 4, 2013	2013_225126_0008	O-000279-13,O-000375-13	Critical Incident System

Licensee/Titulaire de permis

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

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

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street, Clarence Creek, ON, K0A-1N0

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

LINDA HARKINS (126)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 13-14, 2013

During the course of the inspection, the inspector(s) spoke with The administrator, the Director of Care, the Assistant Director of Care,several registered nursing staff,several Personal Support Workers and two residents.

During the course of the inspection, the inspector(s) reviewed two resident's health care records, observed care and services given to residents. The following policies were reviewed;
"Etiquetage des medicaments" SD-INF 2124
"Blessure a la tete" Protocole 6010
"documentation et revisions d'ordonnance" Index No 42

During the course of this inspection, two Critical Incidents were inspected:
Log # O-000375-13 CI 516-000012-13
Log # O-000279-13 CI 516-000009-13

The following Inspection Protocols were used during this inspection:
Falls Prevention

Medication

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 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 failed to comply with O.Reg 79/10, s. 8. (1) b, whereby the home failed to ensure compliance with the following policies:
Medication Administration: Etiquetage de medicaments (SD-INF 2124)
Head Injury(Protocol 6010).

As per O. Reg 79/10, s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

As per O. Reg 79/10, s. 30. (1) 1 There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

On a specified day in March 2013, the Assistant Director of Care (ADOC) noted that the Pharmacy sent a bottle of antidepressant for Resident #1.She immediately called the pharmacy and notified the Pharmacist that Resident#1 was not on an antidepressant and that there was no physician order for that medication. The pharmacy prepared the medications strips for Resident #1 for a period of 7 days in March 2013 and included the antidepressant medication in the strip, even if they were notified by the ADOC, few days prior, that Resident #1 was not prescribed that medication.

During the morning medication pass of a specified day in March 2013, Staff #100 identified one extra pill in Resident #1's medication strip, which was identified as being an antidepressant. Staff #100 notified the ADOC that the medication strip included the the antidepressant for Resident #1. The ADOC followed up with the Nurses who administered medications to Resident #1 for that period in March 2013. It was determined that Staff#101, #102, #103 administered the antidepressant to Resident #1 over a period of 4 days.

Resident #1's condition was deteriorating during that time, having visual hallucinations, nausea and vomiting, decrease balance which resulted in a fall on a specified day in March 2013. Resident #1's condition improved two days later with no apparent adverse effect.

Staff #101 was interviewed by Inspector # 126 and indicated that in his/her nursing practice, he/she was only verifying the medications to be administered as per the Medication Administration Sheet and did not count how many pills that were in the medication strip. Staff #102 and S#103 were not interviewed because they were not in the home at the time of the inspection.

Staff #101, #102 and # 103 did not follow the medication administration policy (SD-INF 2124) in that they did not ensure that the right medication was administered to Resident #1.

2.One evening in March, 2013, Resident #1 fell and hit his/her head. The head injury protocol was initiated at that time. The Head Injury Policy (Protocol 6010) requires that the resident shall be observed every 2 hours during the first 24 hour and shall include waking up the resident every 2 hour during the night.

On that evening, Staff #104 did not wake up Resident #1 at 22hr:30. It is documented in the Neurological Monitoring Sheet (NMS) that Resident #1 was sleeping.

During the night following the fall,staff #105 did not wake up Resident #1 between 01hr:05-05hr:10. It is documented in the Neurological Monitoring Sheet (NMS) that Resident #1 was sleeping.

The next morning, the ADOC documented in the progress notes that it was impossible to awaken Resident #1 but the Resident would respond to pain stimuli. Physician and family were informed of the fall and the medication error.

Two days later, the ADOC documented in the progress notes that when morning care was given to Resident #1, it was observed that she was alert and well awake.

Staff #104 and #105 did not follow the head injury policy by not waking up Resident #1 post fall.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S. O. 2007, c.8 s.6. (10) (b) in that the home did not ensure that Resident's #2 was reassessed when her care needs changed.

In the progress notes of a specified day in May 2013, it is documented by Staff #102 that Resident #2 had a lump on his/her knee, was complaining of pain when touch and that the knee was warm. No other progress notes documented in the health care record related to pain management and monitoring of the knee for the next two days. Resident #2 was sent to hospital on specified day in May 2013 for an x-ray and was diagnoses with a fracture.

Discussion with ADOC and DOC regarding pain management of Resident #2 and they both indicated that they have reviewed the Medications Administration Record sheet for those days and Resident #2 did not received any analgesic. [s. 6. (10) (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 when the resident condition changes reassessment of the resident condition is done to meet their care needs., to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s. 49. (2) in that the home did not ensure that when a resident has a fall, the resident is been assessed with a post fall assessment instrument specifically designed for falls.

Resident #2 fell twice in February 2013 and no post fall assessment instrument was utilized.
Discussion with DOC who indicated that the home does not have a post fall assessment instrument specifically designed for falls. [s. 49. (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 a post fall assessment instrument is used when a resident has a fall., 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:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10 s.131. (1) whereby the licensee administered a medication Resident #1 without a physician prescription.

On a specified day in March 2013, the Assistant Director of Care (ADOC) noted that the Pharmacy sent a bottle of antidepressant for Resident #1.She immediately called the pharmacy and notified the Pharmacist that Resident#1 was not on an antidepressant and that there was no physician order for that medication. The pharmacy prepared the medications strips for Resident #1 for a period of 7 days in March 2013 and included the antidepressant medication in the strip, even if they were notified by the ADOC, few days prior, that Resident #1 was not prescribed that medication.

During the morning medication pass of a specified day in March 2013, Staff #100 identified one extra pill in Resident #1's medication strip, which was identified as being an antidepressant. Staff#100 notified the ADOC that the medication strip included the the antidepressant for Resident #1. The ADOC followed up with the Nurses who administered medications to Resident #1 for the period of that period in March 2013. It was determined that Staff#101, S#102, S#103 administered the antidepressant to Resident #1 over a period of 4 days between.

Resident #1's condition was deteriorating during that time, having visual hallucinations, nausea and vomiting, decrease balance which resulted in a fall on a specified day in March 2013. Resident #1's condition improved two days later with no apparent adverse effect.

Discussion with Director of Care indicated that Staff#101,102,103 have been disciplined related to the medication error involving Resident #1. [s. 131. (1)]

Issued on this 4th day of July, 2013

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

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LINDA HARKINS (126)
Inspection No. / No de l'inspection :	2013_225126_0008
Log No. / Registre no:	O-000279-13,O-000375-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 4, 2013
Licensee / Titulaire de permis :	CENTRE D'ACCUEIL ROGER SEGUIN 435 Lemay Street, Clarence Creek, ON, K0A-1N0
LTC Home / Foyer de SLD :	CENTRE D'ACCUEIL ROGER SEGUIN 435 Lemay Street, Clarence Creek, ON, K0A-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CHARLES LEFEBVRE

To CENTRE D'ACCUEIL ROGER SEGUIN, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee will ensure that the home comply with the following policies:

1) The Registered Nursing staff will comply with "Etiquetage des medicaments", (SD-INF 2124) requires registered nursing staff to ensure that the right medication is administered to the right resident at all times.
2) Nursing Staff will comply with "Blessure a la tete",(Protocole 6010) requires registered nursing staff to ensure that a resident with a head injury will be observed every 2 hours during the 24 hour and will include waking up the resident every 2 hours during the night.
3) The Continuous Quality Improvement (CQI) committee establish a monitoring process when discrepancies or errors in dispensing occurred and to ensure that medication administered to the residents are ordered by a physician.

The risk for this area of non compliance is that there were actual harm to Resident #1 and the scope identified is isolated with a potential of affecting other resident.

Grounds / Motifs :

1. 1. The licensee failed to comply with O.Reg 79/10, s. 8. (1) b whereby the home failed to ensure compliance with the following policies:
Medication Administration: Etiquetage de medicaments (SD-INF 2124)
Head Injury(Protocol 6010).

As per O. Reg 79/10, s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

As per O. Reg 79/10, s. 30. (1) 1 There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

On a specified day in March 2013, the Assistant Director of Care (ADOC) noted that the Pharmacy sent a bottle of antidepressant for Resident #1. The ADOC immediately called the pharmacy and notified the Pharmacist that Resident #1 was not on an antidepressant and that there was no physician order for that medication. The pharmacy prepared the medications strips for Resident #1 for a period of 7 days in March 2013 and included the antidepressant medication in the strip, even if they were notified by the ADOC, few days prior, that Resident #1 was not prescribed that medication.

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Staff #101 was interviewed by Inspector # 126 and indicated that in his/her nursing practice, he/she was only verifying the medications to be administered as per the Medication Administration Sheet and did not count how many pills that were in the medication strip. Staff #102 and S#103 were not interviewed

because they were not in the home at the time of the inspection.

Staff #101, #102 and # 103 did not follow the medication administration policy (SD-INF 2124) in that they did not ensure that the right medication was administered to Resident #1.

2.One evening in March, 2013, Resident #1 fell and hit his/her head. The head injury protocol was initiated at that time. The Head Injury Policy (Protocol 6010) requires that the resident shall be observed every 2 hours during the first 24 hour and shall include waking up the resident every 2 hour during the night.

On that evening, Staff #104 did not wake up Resident #1 at 22hr:30. It is documented in the Neurological Monitoring Sheet (NMS) that Resident #1 was sleeping.

During the night following the fall,Staff #105 did not wake up Resident #1 between 01hr:05-05hr:10. It is documented in the Neurological Monitoring Sheet (NMS) that Resident #1 was sleeping.

The next morning, the ADOC documented in the progress notes that it was impossible to awaken Resident #1 but the Resident would respond to pain stimuli. Physician and family were informed of the fall and the medication error.

Two days later, the ADOC documented in the progress notes that when morning care was given to Resident #1, it was observed that she was alert and well awake.

Staff #104 and #105 did not follow the head injury policy by not waking up Resident #1 post fall. (126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 4th day of July, 2013

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LINDA HARKINS

Service Area Office /
Bureau régional de services : Ottawa Service Area Office