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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 18, 2016	2016_337581_0015	029470-16	Complaint

Licensee/Titulaire de permis

2063415 ONTARIO LIMITED AS GENERAL PARTNER OF 2063415 INVESTMENT LP
302 Town Centre Blvd. Suite #200 MARKHAM ON L3R 0E8

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

Maple Grove Care Community
215 Sunny Meadow Blvd. BRAMPTON ON L6R 3B5

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

DIANNE BARSEVICH (581)

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 5 and 6, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, Personal Support Workers (PSW) and the complainant.

During the course of the inspection the inspector reviewed relevant documents, including but not limited to, resident health records, policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

During the course of this inspection, Non-Compliances were issued.

5 WN(s)
4 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

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 ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

Review of the MDS assessment for resident #001 completed in July 2016, indicated they were incontinent for bowels; however, review of the Bladder and Bowel Continence Assessment completed in August 2016, identified they were continent for bowels. Interview with registered staff #105 stated the resident was incontinent of bowels and that the two assessments were not consistent with each other. [s. 6. (4) (a)]

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

A. Review of the home's Bowel Protocol directed registered staff to administer 30 milliliters (mls) of Milk of Magnesia (MOM) if the resident did not have a bowel movement (BM) in two days, then administer a glycerin suppository if no BM in three days and on the fourth day administer a fleet enema if no BM.

Review of the plan of care identified the bowel protocol was not followed and interventions were not administered as ordered.
i. Review of the clinical record for resident #003 identified they were continent of bowels, frequently incontinent of bladder and were on the bowel protocol. Review of Point of Care (POC) documentation indicated they had a bowel movement on an identified day in August 2016, on evening shift and did not have another bowel movement until four days later on evening shift and no bowel protocol interventions were administered. Review of the electronic medication record (EMAR) revealed they were given a bowel protocol intervention by registered staff on an identified day in August 2016, on day shift which was effective. Interview with registered staff #103 confirmed that the bowel protocol was not administered as ordered when the resident did not have a bowel movement for three days.

ii. Review of POC documentation on an identified day in September 2016, indicated resident #003 had a bowel movement on evening shift and did not have another bowel movement until three days later, on evening shift. Review of the EMAR identified that a bowel intervention was administered on an identified day in September 2016, on day shift and was effective. Interview with registered staff #103 stated the day two intervention was not given until the third day and confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

B. The plan of care for resident #002 revealed they were continent of bladder and bowels and were on the bowel protocol. Review of the bowel protocol identified the protocol was not followed and interventions were not administered on the following dates:

i. On two identified days in August, four identified days in September, and one identified day in October 2016, day two interventions were not administered.
ii. On two identified days in August, two identified days in September 2016, day three interventions were not administered
iii. On one identified day in August, and one identified day in October 2016, day four interventions were not administered.

Interview with registered staff #104 confirmed that the bowel protocol was not followed when the resident did not have a bowel movement on day two, three and four and the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs changed.

The home's policy, Bowel Management Program, policy #VII-D-10.70 revised July 2015, indicated that all residents would be on a bowel management program that promoted regular bowel movements and an individualized bowel routine for each resident was developed. The registered staff would complete a full abdominal nursing assessment, including but not limited to, auscultation for bowel sounds. According to the DOC, the home's bowel protocol directed registered staff to administer 30 millilitres(mls) of Milk of Magnesia (MOM) if the resident did not have a bowel movement (BM) for two days, administer a glycerin suppository if no BM in three days and administer a Fleet emema if no BM in four days and this protocol was to be ordered by the resident's physician.

Resident #001 had a specific diagnosis. They had a written plan of care in place to prevent constipation secondary to a specific diagnosis; however, the bowel protocol was not ordered. Review of Point of Care (POC) revealed that the resident did not have a bowel movement on the following days:
i. two specific days in July, 2016
ii. five specific days in August, 2016
iii. five specific days in September, 2016

Review of the plan of care revealed that the resident was not reassessed related to constipation after the dates above. Interview with registered staff #104 stated the bowel protocol should of been ordered by the physician for resident #001 when they were admitted in July 2016 and confirmed that the resident was not reassessed and the plan of care reviewed and revised when they did not have a bowel movement for two or three days over five different episodes. [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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and that the resident is reassessed and the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs changed, to be implemented voluntarily.

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 failed to ensure that any plan, policy, procedure, strategy, system instituted or otherwise put in place was complied with.

The home had a procedure, "Admission Checklist Registered Staff", which was a 21 day checklist that the registered staff were to complete during the admission process and when it was completed was to be forwarded to the Director of Care (DOC) as part of the monthly audit process.

A. Review of the Admission Checklist for resident #001 identified that registered staff were to initiate a three day bowel and bladder observation record. Review of the plan of care identified that this record was not initiated when the resident was admitted in July 2016. Interview with registered staff #100 stated the admission checklist was not fully completed, not submitted to the DOC in 21 days and confirmed that the three day bowel and bladder observation record was not implemented when resident #001 was admitted.

B. Review of the plan of care for resident #002 identified that the Admission Checklist and the three day bowel and bladder observation record was not initiated when the resident was admitted in May 2016. Interview with registered staff #103 stated that the Admission Checklist was to be completed by registered staff for all residents when admitted to the home and confirmed it was not done. Interview with registered staff #100 confirmed that the three day bowel and bladder observation record was not completed when they were admitted.

C. Review of the Admission Checklist for resident #003 identified that the register staff were to complete a three day bowel and bladder observation record. Review of the plan of care revealed that the record was completed for one shift and this was confirmed by registered staff #106. [s. 8. (1) (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 any plan, policy, procedure, strategy, system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: 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 ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

The plan of care for resident #001 identified they had a specific diagnosis. Review of the progress notes indicated on an identified day in August 2016, they did not have a bowel movement in two days and were given a bowel intervention as per bowel protocol and on an identified day in September, 2016, they did not have bowel movement for three days and a bowel intervention was administered by the registered staff on the night shift. Review of the physician's orders and the Admission Order set identified that the bowel protocol was not ordered. Interview and review of EMAR with registered staff #100 confirmed the bowel protocol was not prescribed for resident #001 and they did receive two bowel medication interventions which were not prescribed. [s. 131. (1)]

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 failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Review of the home's policy, "Medication Pass-MAR/TAR Sheets", index number: 04-02-10, last reviewed on June 23, 2014, indicated that whenever a medication was administered, the nurse or care provider must initial on the MAR sheet opposite that medication for the date and time given. When a PRN dose was given, a time must be entered above or below the registered staff's initials under the appropriate date. In addition to this documentation they must complete the PRN administration record or progress note and outline the effectiveness of the PRN medication.

On an identified day in September, 2016, the progress notes indicated that resident #003 had not had a bowel movement in two days and a bowel medication was administered by registered staff #104, but the resident's response and the effectiveness was not documented. Review of the plan of care identified that the bowel medication was ordered to be given if the resident did not have a bowel movement in two days; however, registered staff #104 did not initial in the medication record the date and time it was given or document the effectiveness and this was confirmed by registered staff #103. [s. 134. (a)]

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 a resident is taking any drug or combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

Review of the Admission Checklist Registered Staff for resident #003 identified that one page of the admission checklist was not in their clinical health record. Interview with registered staff #103 stated they were unable to locate the second page of the checklist and confirmed the home did not maintain their written record. [s. 231. (a)]

Issued on this 27th day of October, 2016

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

Original report signed by the inspector.