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
Jun 23, 2014	2014_289550_0014	O-000300-14	Complaint

Licensee/Titulaire de permis

BRUYERE CONTINUING CARE INC.
43 BRUYERE STREET, OTTAWA, ON, K1N-5C8

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

RESIDENCE SAINT- LOUIS
879 CHEMIN PARC HIAWATHA, OTTAWA, ON, K1C-2Z6

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

JOANNE HENRIE (550)

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): April 29, 2014

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, a Registered Nurse (RN) and a Registered Practical Nurse (RPN)

During the course of the inspection, the inspector(s) reviewed a Resident's health care records, reviewed the home's nursing staffing schedule and observed resident care and services.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Sufficient Staffing

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. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The Licensee failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 3 (1) 11. ii. whereby the residents' right to give or refuse consent to any treatment, care or services for which his or her consent is required by law to be informed of the consequences of giving or refusing consent was not respected.

The progress notes were reviewed for a period of 7 days in March 2014 and the following was noted:

On a specified day in March 2014 Resident #001 was admitted for a 7 day respite care on a specific floor in the home.

On a specified day in March 2014 Resident #001 was wandering on the unit, he/she was entering in other resident's rooms and touching their personal belongings. He/she was crying, pacing the hallways on the unit, going into other resident's rooms and touching their personal belongings. It was noted that other Residents were becoming very upset and there was a risk of altercation with some residents as per the nurse.

On a specified day in March 2014 Resident #001 was wandering on the unit and into other resident's rooms. He/she hit a nurse and a PSW during care.

On a specified day in March 2014 Resident #001 was wandering on the unit, crying and talking to himself/herself. He/she was aggressive with other residents and staff. The Home's physician prescribed a benzodiazepine to be administered s/c stat which was administered at 6:30pm for agitation and aggressive behavior. A message was left to the spouse to inform him/her of his/her spouse's condition but it was not documented in the progress notes. Later that same evening at 8:35pm the Home's physician prescribed a benzodiazepine s/c b.i.d. PRN for agitation.

On a specified day in March 2014 Resident #001 was wandering in the hallway. He/she was agitated and aggressive without provocation after supper. Other residents were afraid of him/her. The Home's physician assessed the resident and clarified the PRN order for the benzodiazepine s/c b.i.d. PRN if the antipsychotic and the antidepressant P.O. are impossible to administer because of ongoing aggressive behaviours and agitation. It was documented in the progress notes and mar-sheets that resident #001 received a benzodiazepine s/c at 6pm. There is no documentation that consent was obtained from the substitute decision maker for the new treatment.

On a specified day in March 2014 during a visit to the Home the resident's spouse/substitute decision maker found his/her spouse to be drugged. When he/she questioned the nurse on duty, she explained to him/her his/her spouse had received a dose of a benzodiazepine because of agitation and aggressive behaviour the evening before. The spouse was upset and he/she told the nurse he/she was not aware of this new medication and had not given his/her consent.

A review of Resident #001's health record indicates resident #001 is unable to make informed decisions regarding his/her care because of his/her cognitive status and that his/her spouse is his/her substitute decision maker. A review of the progress notes indicates no consent was obtained for this new treatment.

The DOC, staff #S100 and #S101 told inspector during an interview that when a new treatment is prescribed, the Home's procedure is to obtain verbal consent by either the Resident or his/her substitute decision maker before the treatment is administered and the consent is to be documented in the resident's chart. The DOC indicated after looking in this resident's chart that no consent had been obtained and documented in the resident's chart before the new treatment was administered. [s. 3. (1) 11. ii.]

Issued on this 23rd day of June, 2014

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