Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 27, 2020	2020_818502_0003	020107-19, 022846-19, 024178-19, 000663-20	Critical Incident System

Licensee/Titulaire de permis

The Religious Hospitallers of St. Joseph of Cornwall, Ontario
14 York St CORNWALL ON K6J 5T2

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

St. Joseph's Continuing Care Centre
14 York Street CORNWALL ON K6J 5T2

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

JULIENNE NGONLOGA (502), JOELLE TAILLEFER (211)

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): January 23, 24, 27, 28, 29 and 30, 2020.

During the course of the inspection the following CIS were inspected refusal was conducted.
- CIS #C565-000023-19 (log #024178-19) related to an unexpected death of a resident.
- CIS #C565-000020-19 (log #020107-19) related to a fall with injury.
- CIS #C565-000001-20 (log #000663-20) related to injury with unknown cause, and
- CIS #C565-000022-19 (log #022846-19) related to an incident of alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Chief Nursing Executive, Nursing Care Coordinator, Physician, Resident Care Aid Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Registered Dietitian, Information Technology, Health, Safety and Education Coordinator, and the residents.

During the course of the inspection, the inspector(s) reviewed several resident's health care records, observed resident care, observed staff and resident interactions, reviewed licensee's investigation notes, reviewed staff schedule, relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
5 WN(s)
5 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	Légende 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the right of resident #004 to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity was fully respected and promoted.

The Ministry of Long-Term Care (MLTC) received a Critical Incident System Report (CIS) related to an allegation of abuse.

Review of the home’s investigation notes indicated that on an identified date, RPN #102 was in an identified area attempting to administer as needed (prn) medication to resident #004 before the provision of care. The resident displayed an identified behaviour toward the RPN. At that time PSW #103 entered the identified area and asked what occurred then the PSW used offensive language toward the resident.

In an interview, PSW #103 indicated that they were assisting the RPN administer resident #004’s medication and the resident displayed the identified behaviour toward them. This contradict PSW #103’s statement during home’s investigation that the resident may have not intend to display the behaviour toward them. The PSW also stated that they were mad and upset when they used offensive language, but they turned and walked away.

In an interview, RPN #101 indicated they were with RN #106 in the TV room, but PSW #103 was not present during the medication administration. The RPN indicated that PSW #103 entered the TV room after the resident spat the medication at them. The PSW asked them what occurred and then began swearing.

In an interview, RN #106 indicated on two occasions, they witnessed PSW #103 not being respectful toward other residents.

In an interview, the NCC acknowledged that the right of the resident to be treated with respect was not respected as the PSW action was very disrespectful. [s. 3. (1) 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 to ensure that the right of the resident to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity is fully respected and promoted, to be implemented voluntarily.

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. (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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

The MLTC received a CIS report related to an injury of unknown cause,

Review of resident #003's current written plan of care indicated that the resident required extensive assistance of two to three staff for bed mobility. The staff are to reposition the resident at least every two hours.

In separate interviews, PSWs #114, #115 and RPN #117 indicated that the resident had a specified condition and they required two to three staff assistance during care.

PSW # 115 indicated that they cared for the resident a night prior to their injury. During

the second round at night, the resident was side way in bed, they changed the resident’s continence care product and repositioned them unassisted using the bed pad. The PSW stated that before the end of their shift, the resident was not fully awake, when they provided care to the resident. When they lifted the resident's hand to place the sling, they noticed the resident’s injury. They stated that they were limited by time toward the end of their shift to provide two-person assistance during.

In an interview, DOC indicated that the logo for transfer and repositioning was posted at every resident’s bed and staff were expected to follow that. The DOC acknowledged that PSW #115 did not provide care as set out in the plan of care, because they provided care to the resident unassisted. [s. 6. (7)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Review of resident #001’s progress notes indicated that on an identified date, RD #111 assessed the resident as a moderate nutritional risk and recommended an identified nutritional supplement twice a day (BID) due to resident’s poor appetite and low body weight.

Review of resident #001’s Nutrition Flow sheet records under Supplements-Fluids for an identified period did not indicate the resident’s Supplement intake.

In an interview, RD #111 stated that the resident’s supplement was sent with meals. RD #111 stated that the documentation in the POC under Nutrition didn’t indicate in the section “Supplements-Fluids” if the resident consumed the supplement.

In an interview, Nursing Care Coordinator (NCC) #105 stated that the resident’s supplement should have been generated by the RD under the Nutrition and Fluids task in the POC. NCC #105 confirmed that the RD did not generate the supplement in POC. Therefore, the provision of the nutritional supplement set out in the plan of care was not documented. [s. 6. (9)]

3. Review of resident #001’s written plan of care, indicated that the resident required two staff assistance for turning and repositioning and direct staff to complete hourly safety check during night shift.

In an interview, PSW #110 stated that they carried out hourly round on the unit during

night shifts. PSW #110 stated for an identified period, a Comfort Care Round sheet was placed above resident's bed to document the hourly round for the day and evening shifts but did not include space for the night shift. The PSW also indicated that POC did not provide space to document hourly round during the night shift except for residents who required bed rails or repositioning. Therefore, they did not document the hourly rounds carried during a specified period for resident #001. [s. 6. (9) 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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan and the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #3: 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 ensure that where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, r. 114. (1), the licensee was required to develop an interdisciplinary medication management system that provides safe medication management and optimized effective drug therapy outcomes for resident.

Specifically, the licensee did not comply with the home's Policy #11-a-122 titled "Diabetic Care Protocol" put in place on March 8, 2017, under the medical interventions.

Review of the home's policy (1) Insulin-dependent diabetics: Fasting Glucometer weekly direct staff to notify the physician if greater than 19.9 mmol/L or less than 4.0 mmol/L and Glucometer testing BID x 48 hours.

Resident #001's health care records indicated the resident had a physician order for an identified medication once a day that was started on an identified date. Two days later, the registered nursing staff documented that the resident's specified test result was 22.6 mmol/L at a specified time and 10 units of the specified medication was administered. On the same day, the physician ordered an additional 6 units of the specified medication, and then 10 units of another specified medication, which were administered to the resident.

On an identified date, RPN #112 documented that the resident was asymptomatic with test result of 1.8 mmol/L 6 hours after the first test and they notified RN #106 of the resident's results, there was no documentation that the physician was notified. The specified protocol was initiated and gradually the resident's test result went to normal range.

On an identified date, the resident's health care records indicated that the specified test result was 12.5 mmol/L..

In an interview, RPN #112 indicated that they brought to the RN's attention resident #001's test result was 1.8 mmol/L. They indicated that they did not notify the physician as it was the RN's responsibility to call the physician when a resident's test result dropped to 1.8 mmol/L.

In an interview, RN #106 confirmed that they did not notify the physician when resident #001's test results dropped to 1.8 mmol/L and they were now aware that they should have called at that time. Therefore, the licensee did not comply with the home's policy "Diabetic Care Protocol" as staff did not notify the physician when resident test result was not within normal range. [s. 8. (1) (b)]

2. Specifically, the licensee did not comply with the Policy # 11-a-120 titled "Use of Glucose Meters/Glucometers" dated September 21, 2016, that the Quality Control testing

will be conducted by Nursing Staff on a regular predetermined schedule and the procedure for quality control testing will be performed as followed:
1. Each RN/RPN will perform a control test in the first week of each month and will document the results on the Glucometer Quality Control Record (Appendix A).
2. Glucometer testing of one resident/patient per month will be completed within fifteen (15) minutes of the resident/patient having a Fasting Blood Sugar drawn by the laboratory. Results are to be documented on the Glucometer Quality Control Record.
3. A control check will be done each time a new bottle of test strips is opened. Enter the results on the Glucometer Quality Control Record. If the test is not in the specified range, do not use the test strips.
4. Forward the Glucometer Quality Control Record to the Director of Care/Director of Nursing at the end of each month.

Review of resident #001’s specified test result on an identified date was within normal range.

Observation made on an identified date in a specified care area by NCC #105, RPN #107 and Inspector #211 did not identify the Glucometer Quality Control Record log book.

In an interview NCC #105 stated that the glucometer quality control testing was not performed on the Glucometer devices for resident #001.

In an interview, RN #109 stated that after resident #001’s incident mentioned above, they recognized that the procedure in the policy titled “Use of Glucose meters/Glucometer” mentioned above was not followed. [s. 8. (1) (b)]

3. In accordance with O. Reg. 79/10, r. 68. (2) (a) the licensee was required to ensure that the programs include, the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration.

Specifically, the licensee did not comply with the Policy # 11-a-190 titled “Resident Fluid Intake-Long-Term Care” put in place on July 19, 2017, indicating that a referral will be made in writing utilizing the Appendix B form titled “Food Service Manager/Dietitian Referral Form” dated July 2017.

Review of the Appendix B form outlined multiple reasons for referral including a resident

consistently missing one (1) meal.

Review of resident #001’s nutrition sheet for an identified period, indicated that the resident refused ten meals and snacks.

In an interview, RD #111 stated they were not aware that resident #001 had constantly refused multiple meals within the last days and a referral was not sent by nor received from the registered nursing staff. Therefore, staff did not comply with the implementation of the home’s policy mentioned above. [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 where the Act or Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers’ instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use all equipment, supplies and devices in the home in accordance with manufacturers' instructions.

The MLTC received a CIS indicating that on an identified date and time, resident #001's specified test was found to be elevated and immediately a second test was completed with another equipment which gave a different result.

Review of the "Contour Next One Blood Glucose Monitoring System Manufacturers' instructions" book dated under "Ascensia Diabetes Care Holdings AG." 2017, indicated that the quality control testing of the "Contour Next One Meter" should be performed using the Contour Next control solution (level 1 and level 2) when:
-Using the meter for the first time.
-Open a new bottle or package of test strips.
-Think your meter may not be working properly.
-Have repeated, unexpected blood sugar results.

In an interview, the Nursing Care Coordinator #105 stated that each resident in the home as their own glucometer sent by their pharmacy service provider. The Nursing Care Coordinator #105 specified that after resident #001's specified incident, they realized that the quality control testing of the "Contour Next One Meter" was not performed and they didn't have a glucometer control testing logbook.

The licensee has failed to ensure that staff used the quality control testing solution in the home in accordance with manufacturers' instructions to verify if the "Contour Next One Meter" device was functioning properly before being used to assess a resident's blood glucose result. [s. 23.]

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 staff use all equipment, supplies and devices in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to ensure that supplies are available at the home to meet the nursing and personal care needs of residents.

In an interview, the Nursing Care Coordinator #105 stated that after resident #001's specified incident, they realized that the quality control testing of the "Contour Next One Meter" was not performed and the Contour Next control solution for testing the quality of the glucometer was not available in the home. The "Contour Next One Meter" quality control testing for all residents was initiated on an identified date, because the quality control testing solution was not available from their pharmacy service provider.

The licensee has failed to ensure that the control testing solution to verify the quality of the "Contour Next One Meters" was available at the home to meet the nursing and personal care needs of residents. [s. 44.]

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 supplies are available at the home to meet the nursing and personal care needs of residents, to be implemented voluntarily.

Issued on this 3rd day of March, 2020

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

Original report signed by the inspector.