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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
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Bureau régional de services de Sudbury
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2016	2016_332575_0002	035945-15	Critical Incident System

Licensee/Titulaire de permis

ALGONQUIN NURSING HOME OF MATTAWA LIMITED
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

ALGONQUIN NURSING HOME OF MATTAWA LIMITED
231 TENTH STREET P.O. BOX 270 MATTAWA ON P0H 1V0

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

LINDSAY DYRDA (575)

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 14 and 15, 2016

This critical incident inspection is related to a fall sustained by a resident.

A follow-up inspection related to two compliance orders issued from inspection #2015_332575_0015 related to the written description for required programs and the on-site hours of the Registered Dietitian was conducted concurrently during this inspection. For details, see inspection #2016_332575_0003.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), a Registered Nurse (RN), Personal Support Workers (PSW), and a resident.

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and reviewed relevant licensee policies, procedures and programs.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **2 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #575 reviewed a critical incident (CI) report submitted to the Director. The CI indicated that resident #001 sustained a fall for which the resident was taken to hospital and sustained an injury. According to the progress notes, the resident returned to the home a few days later.

The inspector interviewed three direct care staff regarding where they would look for direction on the type of care a resident required. PSW #100 and #101 indicated that they would look in the resident's paper health care record at the MDS kardex and care plan. PSW #101 indicated that the electronic Point of Care (POC) also provided tasks and an additional kardex for review. PSW #101 indicated that all records should provide the same information. PSW #103 indicated that they would review the resident's paper care plan located in the resident's health care record.

The inspector reviewed the resident's paper MDS kardex and care plan and electronic POC kardex:

The MDS kardex indicated the type of care the resident required for transferring, locomotion, and toileting.

The resident's care plan indicated different care requirements than indicated in the MDS kardex. In addition, there was a hand written intervention on the care plan, however the

inspector was unable to read the writing. The care plan also indicated that the resident required the use of a device, however it did not provide any directions regarding when the device should be applied or removed. Another intervention provided conflicting information regarding continence care. Under risk for falls, the care plan indicated that staff were to complete a fall risk assessment and a Morse fall scale quarterly.

The POC kardex provided a quick overview of the care required as indicated in the care plan.

The inspector and the DOC reviewed the resident's plan of care. The DOC indicated that the MDS kardex was updated quarterly and that the resident's paper care plan was the most current. The DOC confirmed that the MDS kardex was out of date and provided conflicting instructions regarding the type of care required for this resident. The DOC explained that the home's current practice was to update the paper care plan by hand and then update the MDS kardex quarterly. The DOC was not able to read the hand written interventions and asked the staff member who wrote the interventions to clarify. The interventions were listed on the electronic copy of the care plan, however this is not the care plan accessed by staff. The DOC confirmed that the interventions related to continence care were conflicting. In addition, the DOC indicated that the fall risk assessment was replaced with the Morse fall scale, therefore, the care plan should not indicate for staff to complete both. [s. 6. (1) (c)]

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

Inspector #575 reviewed a critical incident (CI) report submitted to the Director. The CI indicated that resident #001 sustained a fall for which the resident was taken to hospital and sustained an injury. The CI indicated that the resident was not wearing proper footwear at the time of the fall.

A review of the home's internal risk management incident form also revealed that the resident was not wearing proper footwear at the time of the fall.

The resident's plan of care was reviewed. Under the focus risk for falls, an intervention initiated approximately eight months before the fall indicated that the resident was to wear proper and non-slip footwear and that the resident was at high risk for falls.

The DOC confirmed that the resident was not wearing proper footwear at the time of the

fall and that the care set out in the plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 26th day of January, 2016

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

Original report signed by the inspector.

Ontario

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

Ministére 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

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) :	LINDSAY DYRDA (575)
Inspection No. / No de l'inspection :	2016_332575_0002
Log No. / Registre no:	035945-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 22, 2016
Licensee / Titulaire de permis :	ALGONQUIN NURSING HOME OF MATTAWA LIMITED 231 TENTH STREET, P.O. BOX 270, MATTAWA, ON, P0H-1V0
LTC Home / Foyer de SLD :	ALGONQUIN NURSING HOME OF MATTAWA LIMITED 231 TENTH STREET, P.O. BOX 270, MATTAWA, ON, P0H-1V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeremy Stevenson

Ontario

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

Ministére 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

To ALGONQUIN NURSING HOME OF MATTAWA LIMITED, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

1. The licensee shall review and update resident #001's plan of care to ensure that it sets out clear directions to staff and others who provide direct care to the resident.

Specifically, the licensee shall ensure that resident #001's plan of care provides clear directions related to:
-the type of assistance the resident requires for transferring, toileting, mobility/ambulation
-mode of locomotion
-the use of the device
-interventions related to risk of falls

2. The licensee must ensure that the plan of care used by staff, including the MDS kardex, care plan, Point of Care kardex and flow sheets are consistent with the type of care the resident requires.

3. All staff providing direct care to resident #001 must be provided training on the updated plan of care.

4. The licensee must develop and implement a monitoring system that will identify when plans of care do not provide clear directions to staff and that corrective action is taken.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's plan of care set out clear directions to staff and others who provided direct care to the resident.

Inspector #575 reviewed a critical incident (CI) report submitted to the Director. The CI indicated that resident #001 sustained a fall for which the resident was taken to hospital and sustained an injury. According to the progress notes, the resident returned to the home a few days later.

The inspector interviewed three direct care staff regarding where they would look for direction on the type of care a resident required. PSW #100 and #101 indicated that they would look in the resident's paper health care record at the MDS kardex and care plan. PSW #101 indicated that the electronic Point of Care (POC) also provided tasks and an additional kardex for review. PSW #101 indicated that all records should provide the same information. PSW #103 indicated that they would review the resident's paper care plan located in the resident's health care record.

The inspector reviewed the resident's paper MDS kardex and care plan and electronic POC kardex:

The MDS kardex indicated the type of care the resident required for transferring, locomotion, and toileting.

The resident's care plan indicated different care requirements than indicated in the MDS kardex. In addition, there was a hand written intervention on the care plan, however the inspector was unable to read the writing. The care plan also indicated that the resident required the use of a device, however it did not provide any directions regarding when the device should be applied or removed. Another intervention provided conflicting information regarding continence care. Under risk for falls, the care plan indicated that staff were to complete a fall risk assessment and a Morse fall scale quarterly.

The POC kardex provided a quick overview of the care required as indicated in the care plan.

The inspector and the DOC reviewed the resident's plan of care. The DOC indicated that the MDS kardex was updated quarterly and that the resident's paper care plan was the most current. The DOC confirmed that the MDS kardex was out of date and provided conflicting instructions regarding the type of care

required for this resident. The DOC explained that the home's current practice was to update the paper care plan by hand and then update the MDS kardex quarterly. The DOC was not able to read the hand written interventions and asked the staff member who wrote the interventions to clarify. The interventions were listed on the electronic copy of the care plan, however this is not the care plan accessed by staff. The DOC confirmed that the interventions related to continence care were conflicting. In addition, the DOC indicated that the fall risk assessment was replaced with the Morse fall scale, therefore, the care plan should not indicate for staff to complete both.

The decision to issue this compliance order was based on the scope which involved one resident and the severity which has the potential for actual harm for the safety and well-being of this resident. Despite previous non-compliance (NC) issued for this resident during inspection #2015_332575_0015, NC continues with this area of the legislation.
(575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

1. The licensee shall ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan.

Specifically, the licensee shall ensure that the resident is wearing proper footwear at all times and that staff are aware of the interventions related to the risk for falls.

2. The licensee shall develop and implement a monitoring system that will identify when residents are not receiving care as specified in their plans of care and that corrective action is taken.

Grounds / Motifs :

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

Inspector #575 reviewed a critical incident (CI) report submitted to the Director. The CI indicated that resident #001 sustained a fall for which the resident was taken to hospital and sustained an injury. The CI indicated that the resident was not wearing proper footwear at the time of the fall.

A review of the home's internal risk management incident form also revealed that the resident was not wearing proper footwear at the time of the fall.

The resident's plan of care was reviewed. Under the focus risk for falls, an intervention initiated approximately eight months before the fall indicated that the resident was to wear proper and non-slip footwear and that the resident was at high risk for falls.

The DOC confirmed that the resident was not wearing proper footwear at the time of the fall and that the care set out in the plan of care was not provided to resident #001 as specified in the plan.

The decision to issue this compliance order was based on the scope which involved one resident and the severity which resulted in actual harm for this resident. Despite previous non-compliance (NC), NC continues with this area of the legislation. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 08, 2016

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.

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.

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 22nd day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lindsay Dyrda

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