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

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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
Oct 3, 2016	2016_332575_0018	026780-16	Resident Quality Inspection

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), MARIE LAFRAMBOISE (628)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 6-9, 2016.

During the course of the inspection, one critical incident the home submitted related to allegations of staff to resident neglect was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident and Family Services Manager, a Dietary Aide, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. (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 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 in August 2015, regarding alleged staff to resident neglect. The CI indicated that the home received a written complaint regarding resident #006, advising the DOC that they had observed improper care provided to resident #006.

The Inspector reviewed the resident's plan of care which indicated in July 2015, that staff were to apply a device when the resident was in their wheelchair, for prevention of injury. In addition, the plan of care indicated that staff were to monitor the resident on an ongoing basis (hourly) and ensure the documentation included every release of the device, removal or discontinuance.

A physician's order and progress note dated in July 2015, indicated that the resident required a device all times when in their wheelchair.

The Inspector reviewed the home's investigation which indicated that on a certain day in August 2015, PSW #108 failed to apply the device and did not position the resident properly for a period of approximately two hours, after PSW #108 assisted the resident to the washroom.

The Inspector reviewed the documentation which indicated that on a certain day in August 2015, at a certain time, the device was removed and approximately 45 minutes

later, the device was intact. The home's investigation revealed that PSW #109 documented the device was applied for PSW #108, however, it was not applied.

During an interview with the Inspector, the DOC stated that the resident required the use of the device at all times and that they required certain positioning. The DOC confirmed that in August 2015, PSW #108 did not apply the device or properly position the resident as required. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the inspection, it was identified during a staff interview, that resident #003 had three falls in August 2016, within the last 30 days, with no injury.

Inspector #575 reviewed the resident's health care record. The Inspector noted that the risk management report (post fall assessment) for the third fall that occurred in August 2016, indicated that physiotherapy recommended the resident trial the use of a certain device. The Inspector reviewed the resident's care plan which did not identify the use of the certain device.

On September 8, 2016, the Inspector observed the device at the resident's bedside.

During an interview with resident #003, they stated to the Inspector that they used the device to aid in transferring with the assistance of one staff.

During an interview with PSW #104, they stated to the Inspector that they review the electronic care plan on Point Click Care (PCC) for resident care directions. The PSW stated that resident #003 used the device with the assistance of one staff member.

Inspector #628 reviewed the maintenance record binder which documented that the device for resident #003 was installed on a certain day in September 2016.

During an interview with RN #107, they confirmed that the device was not included in the resident's care plan and should be. [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 ensuring that the care set out in the plan of care is provided to resident #006 as specified in the plan, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During stage one of the inspection, it was identified during a staff interview, that resident #003 had three falls in August 2016, within the last 30 days, with no injury.

Inspector #575 reviewed the home's policy titled, "Falls Prevention and Management Program", last revised June 2016, which indicated that after a resident fall, registered nursing staff were to...add the Point of Care (POC) task for post fall vitals for three days, initiate a Head Injury Routine (HIR) for all unwitnessed falls and witnessed falls that have resulted in a possible head injury or if the resident was on anticoagulant therapy, and that the 'Fall and Post Fall Assessment check off list'...was to be completed.

During an interview with RN #107, they stated that after a resident had a fall, the staff were to enter a task on POC and the vital signs were generated under the weights and

vitals tab on PCC. The RN stated that for this resident, the vitals should have been recorded for a period of four days in August 2016 and another period of three days in August 2016. RN #107 stated that staff were required to initiate a HIR if a resident had a fall and was on anticoagulant therapy. During an interview with RPN #105, they stated that staff were to complete the 'Fall and Post Fall Assessment check off list' after each fall.

The Inspector reviewed the weights and vitals tab on PCC for resident #003. The Inspector noted that there were no vitals recorded on five occasions during the specific time period in August 2016. The Inspector reviewed the resident's health care record and noted an incomplete Head Injury Routine (HIR) record with vitals recorded on three occasions. The Inspector noted that the resident was receiving anticoagulant therapy which was discontinued after the second fall in August 2016. A HIR was not completed for the first fall that occurred, and the HIR was incomplete for the second fall that occurred.

The Inspector reviewed the health care record with RN #107. The RN confirmed that the vitals were not recorded in PCC on five occasions. The RN stated that some vitals were recorded on the HIR on two occasions, however, this was not the correct practice.

During an interview with the Inspector, the DOC confirmed that staff did not follow the home's "Falls Prevention and Management Program" policy regarding the documentation of vitals for resident #003, initiating a HIR for two falls that occurred (as the resident was receiving anticoagulant therapy), and not completing the 'Fall and Post Fall Assessment check off list' for the third fall that occurred. [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 ensuring that the Falls Prevention and Management Program policy is complied with, 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 has failed to ensure that when the resident has fallen, the resident was assessed and, if required, a post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During stage one of the inspection, it was identified during a staff interview, that resident #003 had three falls in August 2016, within the last 30 days, with no injury.

Inspector #575 reviewed the home's policy titled, "Falls Prevention and Management Program", last June 2016. The policy stated that when a resident has fallen, registered staff were to complete the post fall risk management in PCC to capture the potential contributing factors and risk for future falls.

During an interview with RPN #105, they stated that after a resident had a fall, the staff were to complete the risk management report (post fall assessment) on PCC.

Inspector #575 reviewed the resident's health care record and risk management reports on PCC. The Inspector noted that for the third fall that occurred in August 2016, the risk management report was incomplete; predisposing factors were not recorded.

During an interview with the DOC, they confirmed that the risk management report was incomplete and that the staff should have completed the predisposing factors. [s. 49. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the date and time of the incident.

Inspector #575 reviewed CI report submitted to the Director in August 2015, regarding alleged staff to resident neglect. The CI indicated that the DOC received a written complaint regarding the improper care of of resident #006.

The Inspector reviewed the written complaint which was sent via email to the DOC one day prior (than the date indicated on the CI).

The home's investigation indicated that the incident occurred one day prior than the date indicated on the CI.

The DOC confirmed that the incident occurred on a certain day in August 2015, not on the original date specified in the CI report. [s. 104. (1) 1.]

Issued on this 3rd day of October, 2016

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

Original report signed by the inspector.