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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 31, 2014	2014_284545_0007	O-000990-13 X O-001217-13	Critical Incident System

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

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

CARESSANT CARE BOURGET
2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0

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

ANGELE ALBERT-RITCHIE (545)

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): March 10, 11, 12, 13 and 14, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), the RAI Coordinator, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the Health Records for Resident #1 and Resident #2, Safety Plan - Resident Policy and Procedure reviewed September 2013, Fall Prevention and Code C.A.R.E. training attendance sheets for 2013 and observed care and services provided to Residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Responsive Behaviours

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. 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).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c) in that the licensee did not ensure that the plan of care set out clear directions to staff

and others who provided direct care to the Resident #1 and Resident #2.

In a review of the Plan of Care for Resident #1, it indicated that Resident #1 was diagnosed with unspecified osteoporosis and dementia. Resident #1 wandered in and out of other Residents' rooms and on the unit due to restlessness and was identified as a high risk for falls with a history of falls. Resident #1 had an unwitnessed fall on a specific date in 2013, was sent to the hospital for a fracture and passed away post-surgery.

The Plan of Care created in April 2013 indicated that staff were to check Resident #1 every hour to ensure safety due to Resident #1's high risk for falls, use of psychotropic medications, unsteady gait, cognitive impairment and that Resident #1 never called for assistance.

On a specific date in March 2014, PSW S#105 indicated that Resident #1 was monitored closely. When asked to describe what "closely monitored" meant, PSW S#105 responded that sometimes he/she brought Resident #1 to the living room and they watched TV together.

During an interview with the Director of Nursing and Administrator on March 12, 2013, they indicated that the home's electronic plan of care did not include hourly checks for safety, therefore PSWs would not have monitored and documented Resident #1 hourly for safety.

During interviews with PSW S#108 and PSW S#102 on March 12, 2014, they indicated that if Resident #1 was on hourly check, it would have been assigned as a task in Resident #1 Point of Care's (POC) documentation (electronic plan of care).

In reviewing the PSW Intervention/Task report for Resident #1 for a period of ten days in October 2013 there was no task indicating a need to check Resident #1 on an hourly basis.

The Administrator and the Director of Nursing both indicated that the plan of care did not provide clear directions to staff in regards to hourly safety monitoring for Resident #1. [s. 6. (1) (c)]

2. In a review of the Plan of Care for Resident #2, it indicated that Resident #2 was diagnosed with Dementia, Parkinsonian symptoms, including cardiac and pulmonary

diseases. Resident #2 was admitted to the home in March 2013 and was immediately identified as a high risk for falls due to unsteady gait. Resident #2 was observed by PSW on a specific day in December 2013, with a rotation of a limb while in his bed with two full bedside rails in up position . Resident #2 was sent to hospital with a fractured limb and passed away post-surgery.

The plan of care updated on a specific date in November 2013 indicated that staff were to check Resident #2 every hour to ensure safety due to a high risk for falls.

During an interview with PSW S#111 on March 14, 2014, it was indicated that Resident #2 required two staff for all transfers. Staff S#111 stated that Resident #2 was at risk for falls because he/she was unsteady and he/she had many falls in the past. PSW indicated that both full bed rails were always in up position when Resident #2 was in bed to prevent him/her from getting out of bed and falling. PSW indicated that Resident #2 sometimes tried to get out of bed by putting his/her legs over the railings. When asked how the monitoring for Resident #2 was done, PSW responded that he/she kept an eye on Resident #2 while working on the unit. PSW S#111 indicated that no report or documentation of hourly checks were done to ensure safety for Resident #2.

In reviewing the PSW Intervention/Task report for Resident #2 for for period of one week prior to incident on a specific date in December 2013 there was no task indicating a need to check Resident #2 on an hourly basis.

During an interview with the Director of Nursing and the Administrator on March 12, 2014 they indicated that PSW have access to the Residents' plan of care and that they were expected to document care provision in the Resident's electronic files. In an interview with the Director of Nursing on March 14, 2014, she indicated that when “checking every hour is indicated in the plan of care” the home’s expectation is for staff to observe hourly, report what was observed then document reported observation in a progress note each time the observation took place.

As such the plan of care did not set out clear directions to staff and others who provided direct care to the Resident #1 and Resident #2. [s. 6. (1) (c)]

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 in ensuring that the plan of care provides clear direction to all direct care staff who provide direct care to residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.221 (1) 1 in that the home did not ensure that all direct care staff are provided training in falls prevention and management.

In reviewing Bourget Staff Education for 2013, it was indicated that 47% of the direct care staff received Fall Prevention training in 2013, which included review of Falls Prevention Policies and Procedures.

During an interview with the Director of Nursing on March 14, 2014, she indicated that the Home implemented Code C.A.R.E. as part of the Falls Program in 2013 and stated that staff were provided with training. In a review of the Code C.A.R.E. attendance sheets, it indicated that 31% of the direct care staff received Code C.A.R.E. training in May 2013. Of the 47% direct care staff that received Falls Prevention Training in 2013, 10% received Code C.A.R.E as well.

In an interview with PSW S#111 on March 14, 2014, it was indicated that he/she was unaware of Code C.A.R.E. and didn't know what it stood for.

As such the home did not ensure that all direct care staff was provided training in falls prevention and management in 2013. [s. 221. (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 all direct care staff are provided with Fall Prevention and Management training in 2014, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s.31 (2) 4 in that licensee did not ensure that Resident #2's restraint plan of care included an order by the physician.

In reviewing the RAI-MDS 2.0 assessment completed by the RAI Coordinator on a specific date in November 2013, it was documented that Resident #2's Cognitive Performance Scale score had deteriorated by two points on the Cognitive Performance Scale score as compared when assessed in June 2013, and that full bed rails on all open sides of bed were used daily.

In an interview with PSW S#111 on March 14, 2014, it was indicated that both full bed rails were always in up position when Resident #2 was in bed to prevent him/her from getting out of bed and falling.

During a review of Resident #2's health record, documentation of an order by the physician for 2 full bed rails when Resident #2 was in bed, could not found.

In an interview with the Director of Nursing on March 14, 2013 she indicated that the physician had not provided an order for the use of two full bed rails while Resident #2 was in bed.

As such, the restraint plan of care for Resident #2 did not include an order by the physician for 2 full bed rails when Resident #2 was in bed. [s. 31. (2) 4.]

2. The licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s.31 (2) 5 in that licensee did not ensure that Resident #2's restraint plan of care included the consent by the substitute decision maker (SDM).

In a progress note on a specific date in November 2013 it was indicated that the Director of Nursing had faxed a note to the SDM to request a consent for the use of restraints.

During a review of Resident #2's health record, documentation of a signed consent form by the substitute decision maker (SDM) for 2 full bed rails when Resident #2 was in bed, could not found.

In an interview with the Director of Nursing on March 14, 2014 she indicated that Resident #2's SDM was difficult to reach and many attempts had been made to him/her to obtain a consent.

As such, Resident #2's plan of care did not include the consent by the Resident's SDM for the use of restraints. [s. 31. (2) 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s.107 (3) 4 in that the home did not ensure that the Director was informed within one business day of an incident that caused an injury to Resident #2 for which this Resident was taken to a hospital and that resulted in a significant change in the Resident #2's health condition.

In an interview with Registered Staff S#104, it was indicated that Resident #2 was found lying in bed after 1pm on a specific date in December 2013 in distress with a limb internally rotated.

In an interview with Registered Staff S#100, it was indicated that following his/her assessment of Resident #2's limb, it was thought that the limb was fractured due to an internal rotation and the severe pain Resident #2 was exhibiting. Registered Staff S#100 indicated he/she directed RPN to contact the physician immediately, and just before 2pm on a specific date in December 2013, Resident #2 was sent to hospital by ambulance, and had hip surgery.

The Home informed the Director via a Critical Incident Report they submitted on a specific date in December 2013; two business days following the occurrence of the critical incident. [s. 107. (3) 4.]

Issued on this 31st day of March, 2014

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