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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2017	2017_548592_0020	019238-17	Resident Quality Inspection

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

The Palace
92 CENTRE STREET ALEXANDRIA ON K0C 1A0

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

MELANIE SARRAZIN (592), JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 25, 26, 27, 28, 29 and October 02, 2017

During the course of the inspection, the inspector(s) also conducted two critical Incidents, inspection log # 011217-17 and log # 003352-17 (fall resulting in fracture).

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, a member of Residents’ Council, Chair of Family Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Laundry Aid, Director of Activity (DOA), Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents’ health care records, home policies and procedures, staff work routines, observed resident rooms, observed resident common areas, reviewed the Admission process and Quality Improvement system, reviewed Residents' Council and Family Council minutes, observed a medication pass, the delivery of resident care and services and staff/resident interaction.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
2 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. (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 resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(c) care set out in the plan has not been effective.

This inspection is related to Log #011217-17.

On a specified date, a Critical Incident report was submitted to the Director reporting an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. It was reported that on a specified date, staff heard resident #022 calling out from his/her bedroom and found the resident sitting on the floor in the doorway of his/her bedroom/bathroom. Upon assessment, it was noted by RPN #101 that the resident was expressing pain to a specific body part. The resident was transferred to hospital where he/she was diagnosed with an injury to a specific body part and required interventions.

A review of resident #022's health care records on September 28, 2017 by inspector #550 revealed that the resident was admitted to the home on a specified date in 2016 with multiple health conditions. It was documented in the progress notes that resident #022 fell three times in a specified month in 2017. The first incident, the resident was found on the floor in his/her room and had sustained an injury to a specific body part for which the resident had to be transferred to the hospital where he/she received interventions. The second incident, the resident was found on the floor beside his/her bed and had sustained an injury to two specific body parts. The latest incident was as described above. The care plan in place at the time of the resident's falls, identified the resident to be at high risk for falls and identified five interventions to mitigate falls. The current care plan in place was also reviewed. It identified the resident to be at high risk for falls and the same five interventions in place to mitigate falls.

On September 28, 2017, inspector #550 observed the resident sleeping in bed with a specific device in place. On September 29, 2017, inspector #592 observed the resident sitting in a wheelchair with another specific safety device in place.

During interviews on September 28, 29 and October 02, 2017, PSW #110, #104 and #114 indicated to inspector #550 and #592 that resident #022 is at high risk for falls because he/she tries to transfer himself/herself on his/her own and does not remember he/she cannot walk alone. The resident has five specifics interventions in place to prevent falls. PSW #110 indicated to inspector #550 that the interventions have not changed since the resident's three falls ; they are the same as before. The DOC indicated to inspector #550 during an interview that the interventions in place prior to the resident’s falls are the same as the current interventions. She indicated that they have not tried any other interventions in an attempt to prevent the resident from falling when the current interventions were proven to be ineffective.

On October 2, 2017, the ADOC indicated to inspector #550 that she was not aware of other interventions they could try to prevent the resident from falling.

As such, the plan of care for resident #022 was not reviewed and revised when the care set out in the plan was not effective. [s. 6. (10) (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 to ensure that resident #022 plan of care will be reviewed and revised when the care set out in the plan for fall prevention has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
6. Any other areas provided for in the regulations.

In accordance with O. Reg. 79/10, 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 (2) indicates that the licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7).

This inspection is related to Log #011217-17.

On a specified date, a Critical Incident report was submitted to the Director reporting an incident that caused an injury to a resident for which the resident was taken to hospital

and which resulted in a significant change in the resident’s health status. It was reported that on a specified date, staff heard resident #022 calling out from his/her bedroom. When staff arrived in the resident’s room, they found the resident sitting on the floor in the doorway of his/her bedroom/bathroom. Upon assessment, it was noted by RPN #102 that the resident was expressing pain to a specific body part. The resident was transferred to hospital where he/she was diagnosed with an injury which required interventions. The home’s investigation determined that human error could have contributed to the resident’s fall. Prior to the fall, a RPN had responded to the activation of a specific safety device and toileted the resident. It is possible that the safety device was not reset properly after the resident was taken to the washroom by the RPN or that the resident was not positioned properly to ensure that the safety device was activated.

A review of resident #022’s health care records on September 28, 2017 by inspector #550 revealed that the resident was admitted to the home on a specified date in 2016 with multiple health conditions. The actual care plan identified the resident to be at high risk for falls and had five specific interventions in place to mitigate falls.

On September 28, 2017, inspector #550 observed the resident sleeping in bed with a specific safety device in place. The inspector observed that the safety device was not functional, therefore would not be activated if the resident got out of bed. On October 2, 2017, inspector #550 observed the same safety device to be “off” and the resident was not in bed.

During an interview PSW #110 indicated to inspector #550 that resident #022 is at high risk for falls because he/she tries to transfer himself/herself on his/her own and does not remember he/she cannot walk alone. When the resident is in bed, staff have to make sure the resident has a specific safety device in place so it will notify them when the resident is trying to get out of bed. PSW explained to the inspector how to operate the safety device. Inspector showed the PSW that the safety device was not “on” and the resident was in bed. The PSW indicated that she never knew she had to verify the safety device was “on”, that she thought that it was “on” all the time. She then activated the safety device and a green lite up indicating that the device was “on”.
PSW #104 and #114 indicated to inspector #592 during an interview on September 29 and October 2, 2017, that the safety device for resident #022 is never turned “off”, therefore they do not have to turn it “on”. PSW #104 indicated to inspector #592 that she did not remember when she received education on how to use this specific type of safety device. RPN indicated to inspector #550 that she does not remember when she received training on how to operate and use the specific safety device.

During an interview, the DOC indicated that the specific safety device is a tool used by staff to prevent falls as part of their fall prevention program. She further indicated that the education was not provided to staff on the use and operation of the specific safety device except for approximately three RPNs (including the RPN who had toileted the resident prior to her fall). She indicated that staff do approximately twenty five hours of training on Surge learning which included fall prevention and management. The DOC further indicated that the education does not include how to operate this specific type of safety device. She indicated that there are many different kinds of this type of safety device used in the home and that she was under the impression that staff were aware how this safety device functioned and how to apply it.

As evidenced above, staff who provide direct care to residents did not receive education on how to use the safety devices prior to using them. [s. 76. (7)]

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 staff who provide direct care to the residents receive the training on the equipment used for the fall and prevention program, to be implemented voluntarily.

Issued on this 4th day of October, 2017

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

Original report signed by the inspector.