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

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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
May 12, 2015	2015_266527_0010	H-002109-15	Critical Incident System

Licensee/Titulaire de permis

CORPORATION OF THE COUNTY OF DUFFERIN
151 Centre St SHELBURNE ON L0N 1S4

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

DUFFERIN OAKS
151 CENTRE STREET SHELBURNE ON L0N 1S4

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

KATHLEEN MILLAR (527)

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): May 4, 5 and 6, 2015.

The inspection included the following critical incidents: H-002109-15 and H-002420-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Minimum Data Set/ Resident Assessment Instrument (MDS/RAI) Coordinator, the Unit Coordinators for the 1st and 2nd floors, the Physiotherapist, the registered staff and the Personal Support Workers (PSWs).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

A) In March 2015, resident #001 had a fall. The resident was later transferred to the hospital where the resident was diagnosed with a significant injury. The registered staff had documented in the progress note that a post-fall assessment was not applicable. In an interview with the registered staff, the unit coordinator, the Falls Lead and the DOC confirmed that registered staff were expected to document in the progress notes the post-fall assessment and the resident's responses to the interventions. The clinical record was reviewed and there was no documentation of the post-fall assessment, or the resident's response to the interventions in the progress notes.

B) In April 2015, resident #002 had a fall. The direct care staff were interviewed and the clinical record reviewed. Both the interviews and the clinical record identified resident #002 had bruising; however, the resident had no other injuries as a result of the fall. Several days later the resident was transferred to the hospital where the resident was diagnosed with a significant injury. The registered staff had documented the skin assessment in the progress note, which asks for the details, injuries and head to toe assessment in the post-fall assessment section. There was no other documentation by registered staff related to the post-fall assessment. In an interview with the registered staff, the Unit Coordinator, the Falls Lead and the DOC, they confirmed that registered staff were expected to document in the progress notes the post-fall assessment and the resident's responses to the interventions. The clinical record was reviewed and the documentation of the post-fall assessment, or the resident's response to the interventions in the progress notes did not meet the expectations of the home. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: 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 failed to 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.

A) In January 2015, the Fall Risk Assessment was completed to determine the level of falls risk for resident #001, and in February 2015, the MDS Assessment was completed. Both assessments identified that resident #001 was at low to moderate risk for falls. The resident had no previous history of falls; however, in March 2015 the resident experienced a fall. The resident was later transferred to the hospital where the resident was diagnosed with a significant injury. The clinical record was reviewed and there was no post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. The DOC, the Falls Lead and registered staff were interviewed and they confirmed they no longer use a post-fall assessment instrument that was specifically designed for falls.

B) In April 2015, the MDS Assessment was completed and the Fall Risk Assessment to determine the level of falls risk for resident #002. Both assessments identified that resident #002 was at low to moderate risk for falls. The resident had no previous history of falls; however, in April 2015 the resident experienced a fall. The resident was later transferred to the hospital where the resident was diagnosed with a significant injury. The direct care staff interviewed and the clinical record identified the resident bruising from the fall; however, the resident had no other injuries. In April 2015, the resident was transferred to the hospital where he was diagnosed with a significant injury. The clinical record was reviewed and there was no post-fall assessment conducted using a clinically appropriate assessment instrument that was specifically designed for falls. The DOC, the Falls Lead and registered staff were interviewed and they confirmed they no longer use a post-fall assessment instrument that was specifically designed for falls. [s. 49. (2)]

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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #002 was admitted to the home in March 2015. The 24-hour admission care

plan identified the resident "was fine for bladder and bowel and required no continence product". The MDS Assessment completed in April 2015 identified the resident was occasionally incontinent for bowel and frequently incontinent for bladder. The Bowel and Bladder record completed by the PSWs for seven days post admission identified that the resident was self toileting and was occasionally incontinent and infrequently incontinent of bowel. The Admission Bladder and Bowel Continence Assessment completed by the registered staff in April 2015 was incomplete and did not identify the causal factors, patterns, type of incontinence and potential to restore function with specific interventions.

The registered staff were interviewed and confirmed that the Bladder and Bowel Continence Assessment was not completed. The home's policy called "Continence Care and Bowel Management Program", policy number 1-660, was revised April 2014 and 2015. This policy directed the registered staff to complete the Bladder and Bowel Assessment on admission of the resident. The DOC was interviewed and identified that when these assessments were collated then an individualized continence plan of care would be developed and implemented to meet the needs of this resident. The registered staff and the DOC confirmed the bladder and bowel assessment was not conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the condition of the resident required it. [s. 51. (2) (a)]

2. The licensee has failed to ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

The MDS Assessment for resident #002 was completed in April 2015, and identified the resident was occasionally incontinent for bowel and frequently incontinent for bladder. The Bowel and Bladder record completed by the PSWs for seven days post admission identified that the resident was self toileting and was occasionally incontinent for bladder and infrequently incontinent of bowel. The assessment and response codes on the Bowel and Bladder record were not documented, and when reviewed with several PSWs they stated that it would not assist in identifying what the resident's needs were for continence care. The Admission Bladder and Bowel Continence Assessment were supposed to be conducted by the registered staff in April 2015, and it was incomplete.

The DOC was interviewed and identified that these assessments would be the basis for the development and implementation of the individualized continence plan of care to meet the needs of this resident. The LTC Inspector reviewed the continence

assessments and documentation in the plan of care with the DOC. The DOC confirmed there were inconsistencies in the resident's continence status, and with the incomplete bladder and bowel assessments; the plan of care was not individualized to promote and manage the resident's bowel and bladder continence. [s. 51. (2) (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, (a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible.

Resident #002 was admitted to the home in March 2015. In the Community Care Access Centre (CCAC) report provided to the home identified that the resident had inappropriate behaviours. The progress notes were reviewed and the resident was exhibiting responsive behaviours daily since admission. There were no behavioural triggers identified in the plan of care. Only two of the behaviours identified were in the plan of care; however they were not initiated and interventions not identified until several weeks after the resident's admission. The Behavioural Support Officer (BSO) was interviewed and confirmed that behavioural triggers should have been identified. The BSO also confirmed that there was no referral for consultation to assist with the resident's responsive behaviours. The home's policy called "Responsive Behaviours Prevention and Management Program", policy number 1-1830, was revised April 2015. This policy directs staff to document the identification of behavioural triggers for the resident demonstrating responsive behaviours in the plan of care. The BSO and the DOC confirmed that the behavioural triggers should have been identified for this resident and documented in the plan of care. [s. 53. (4) (a)]

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, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, to be implemented voluntarily.

Issued on this 20th day of May, 2015

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

Original report signed by the inspector.