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
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 22, 2014	2014_278539_0012	H-000759	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

VALERIE GOLDRUP (539)

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 20, May 21 and May 22, 2014.

The following log numbers were completed during this inspection: H-000759-13, H-000752-13 and H-000394-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC),Registered Nursing staff including Registered Practical Nurses and Registered Nurses, Personal Support Workers (PSW), residents and family members of residents.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed health care records, investigation reports, human resource files, relevant policies, procedures and practices and interviewed staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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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. 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 of the long-term care home did not put in place a policy that is in compliance with and is implemented in accordance with applicable requirements under the Act. O. Reg. 79/10, s. 8 (1)a.

In October, 2013, a resident was heard to fall to the ground from their bed. When the Personal Support Worker found the resident on the floor the hand held control for the bed was on the bed and the bed was raised to a high position. The investigation determined the resident had attempted to get up from this height in stocking feet and slipped and fell. The resident was responded to, assessed and transferred to hospital. They were diagnosed with two fractures and subsequently died in hospital.

The bed was equipped with two rectangular quarter bed rails. The left bed rail held the remote control pendant to raise and lower the bed. The bed rail was noted on the care plan for resident use to assist with transfers and assist with bed mobility. This was confirmed with a member of the Registered Nursing staff and the Director of Care.

The Administrator confirmed that the home did not consider quarter bed rails a PASD. A member of the Registered Nursing staff and the Director of Care confirmed that there is no organized process to assess for quarter bed rails as a PASD.

The home's Restraint and Personal Assistance Safety Device (PASD) policy effective December, 2010 and revised October, 2012 stated that a PASD is a device used to assist a person with a routine activity of living. However, the bed rail policy 1-1940 effective June, 1982 and revised May, 2006 did not include quarter rails as a PASD. The bed rail policy had not been revised or updated to reflect the more current policy that reflects the use of all possible PASD requiring an assessment.

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 be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

In October, 2013, a resident was heard to fall to the ground from their bed. When the Personal Support Worker found the resident on the floor the hand held control for the bed was on the bed and the bed was raised to a high position. The investigation determined the resident had attempted to get up from this height in stocking feet and slipped and fell. The resident was responded to, assessed and transferred to hospital. They were diagnosed with two fractures and subsequently died in hospital.

The bed was equipped with two rectangular quarter bed rails. The left bed rail held the remote control pendant to raise and lower the bed.

Personal Support Worker (PSW) and a member of the Registered Nursing staff confirmed that the resident had returned to their room after dinner and was independent with a walker to transfer to and from the bed and toilet themselves. According to staff, the resident was able to ring the call bell for assistance as required. However,the resident assessments included a Mini-Mental Assessment Evaluation of 20/30 which indicated ~~moderate~~ MILD cognitive impairment. The resident plan of care noted that the resident had impaired eyesight and vision loss.

Valerie Golding August 21, 2014

The manufacturer instructions for the attached remote control pendant noted that a resident "with reduced mental acuity should not be allowed to access the pendant. Unsupervised use of pendant could result in injury or death". Clinical documentation for the resident was reviewed and the home did not complete an assessment of the resident for the use of the remote control pendant.

A member of the Registered Nursing staff and the Director of Care confirmed that there is no organized process to assess for the use of the attached remote control pendant. [s. 23.]

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 be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 1. Alternatives to the use of a PASD have been considered, and tried

where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 3. The use of the PASD has been approved by, i. a physician, ii. a registered nurse, iii. a registered practical nurse, iv. a member of the College of Occupational Therapists of Ontario, v. a member of the College of Physiotherapists of Ontario, or vi. any other person provided for in the regulations. 4. The use of the PASD 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. 33 (4).

In October, 2013, a resident was heard to fall to the ground from their bed. When the Personal Support Worker found the resident on the floor the hand held control for the bed was on the bed and the bed was raised to a high position. The investigation determined the resident had attempted to get up from this height in stocking feet and slipped and fell. The resident was responded to, assessed and transferred to hospital. They were diagnosed with two fractures and subsequently died in hospital.

The bed was equipped with two rectangular quarter bed rails. Interview with a Personal Support Worker and Registered Nursing staff confirmed that the bed was equipped with two rectangular quarter bed rails which were raised at the time. The left bed rail held the remote control pendant to raise and lower the bed. The bed rail was noted on the care plan for resident use to assist with transfers and assist with bed mobility. This was confirmed with a member of the Registered Nursing staff and the Director of Care.

The home's Restraint and Personal Assistance Safety Device (PASD) policy stated that a PASD including bed rails required a prescription, assessment, and consent completion. However, the bed rail policy 1-1940 dated May, 2006 did not include quarter rails as a PASD.

Clinical documentation for the resident was reviewed and there was no documented PASD assessment for the quarter bed rails as a PASD.

The Administrator confirmed that the home did not consider quarter bed rails a PASD. A member of the Registered Nursing staff and the Director of Care confirmed that there is no organized process to assess for quarter bed rails as a PASD.

Again clinical documentation for the resident was reviewed and there was no documented approval of the quarter bed rails as a PASD and consent was not obtained by the home from the resident or the Substitute Decision Maker for the quarter bed rails to be used as a PASD. This was confirmed with a member of the Registered Nursing staff and the Director of Care. [s. 33. (4)]

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 be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee of the home did not ensure that procedures and interventions were developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of alterations and potentially harmful interactions between and among residents.

In September, 2013 resident #1 struck resident #3 causing resident #3 injury to their face. The incident occurred in a common area. No employees were in attendance at the time of the incident. The physician and family members of those involved were contacted. A message was left after hours notifying the Ministry of Health and a written critical incident report was submitted.

Resident #1 had been assigned ongoing one to one staff monitoring on the day and evening shift since August 19, 2013 due to concerns regarding resident #1's behaviour. Registered Nursing staff interviewed stated that resident #1 had not hit another resident before the event in September, 2013. Registered Nursing staff confirmed that on the evening shift of September 1, 2013 there was no one to one staff assignment to monitor resident #1. This was due to a lack of staff availability. The Director of Care confirmed that prior to the incident there were some occasions during the summer months where one to one staff was not available due to vacations.

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 be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee of the home did not ensure that residents were treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity.

The following two events outlined below involved the same employee and were reported to the home.

In March, 2014, resident #1 identified to a staff member that an employee had raised their voice to the resident and spoke in a manner that made the resident cry. The resident had not eaten supper and when the employee was notified of this, the employee was noted to respond "that's your fault, you wouldn't take it". The staff member did not provide additional food to the resident until the evening snack was received. The events of the incident were reviewed and confirmed with a member of the Registered Nursing staff.

In March, 2014, resident number #2 identified to a staff member that an employee had told the resident they "smelled bad" and the room stunk. When speaking with the resident, the resident confirmed that the encounter with the employee upset them. The events of this incident were confirmed with a member of the Registered Nursing staff, the resident and the next-of-kin.

Staff reported the allegation of abuse to the Registered Nursing staff; the home notified the Ministry of Health, of the alleged incident and submitted a critical incident report to the Ministry of Health. The employee was reprimanded and received a written discipline and provided with a copy of the homes abuse policy to review.

Issued on this 12th day of August, 2014

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