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

London Service Area Office
130 Dufferin Avenue, 4th floor
LONDON, ON, N6A-5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin, 4ème étage
LONDON, ON, N6A-5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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 21, 2014	2014_226192_0021	L-000469-14	Critical Incident System

Licensee/Titulaire de permis

TRI-COUNTY MENNONITE HOMES
200 Boullee St., New Hamburg, ON, N3A-2K4

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

NITHVIEW HOME
200 Boullee Street, New Hamburg, ON, N3A-2K4

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

DEBORA SAVILLE (192)

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): June 11, 12, 2014

This inspection was conducted concurrently with Follow-up Inspection L-000580 -14 inspection number 2014_226192_0021.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistance Director of Care, Behaviour Supports Ontario (BSO) Registered Practical Nurse, registered staff and a Substitute Decision Maker.

During the course of the inspection, the inspector(s) observed the provision of resident care, reviewed medical records, incident reports and policy and procedure.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
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. (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 failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan.

A) The plan of care for resident #003 indicated that when wandering and becoming aggressive the resident was to be checked every 5-10 minutes to ensure the safety of those around them and themselves, if continuing the behaviour someone was to be with them at all times until help arrived.

The plan of care initiated in 2014 indicated to monitor resident #003 every 15 minutes when they are agitated and wandering the halls.

Resident #003 is noted to have wandered into other resident rooms in 2014. A progress note identified that the resident demonstrated increased pacing, going into other rooms and increased agitation.

A second progress note in 2014 indicated that resident #003 was pushed and sustained a fall after attempting to enter another residents room.

Record review and interview with registered staff and the Director of Care confirmed that there is no documentation to confirm that resident #003 was monitored every 15 minutes or more frequently when there was increased wandering into other resident's rooms and agitation. Interview also confirmed that there was no documentation that staff were reminded to increase supervision due to escalating pacing and agitation that put the resident at risk.

B) Resident #002 is identified to demonstrate aggression toward other residents.

The plan of care indicated that resident #002 required a specified intervention to protect other residents.

Interview with registered staff and family confirmed that the intervention is frequently not completed.

It was observed that the intervention was not completed to protect other residents. Resident #002 was confirmed to be in the room, unsupervised during this observation. Several staff members were observed to pass the resident's room without implementing the intervention.

Care was not provided to residents #002 and #003 as specified in their plan of care. [s. 6. (7)]

2. The licensee failed to 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, care set out in the plan has not been effective.

Resident #002 was identified to be aggressive toward other resident's under specified conditions.

On a specified date in 2014 resident #002 was aggressive with two residents causing both residents to sustain falls.

The progress notes indicated that an intervention was initiated.

On a specified date in 2014 resident #002 pushed another resident causing injury.

On a specified date in 2014 the specified intervention was added to the plan of care.

On a specified date in 2014 during family conference, the family expressed concern that the intervention was ineffective.

Interview with registered staff confirmed that other residents put themselves at risk in spite of the intervention in place.

On a specified date in 2014 the medical record indicated that a resident was pushed to the floor by resident #002.

On a specified date in 2014 the medical record indicated that resident #002 was slapping a resident.

Interview with registered staff confirmed that the effectiveness of the intervention had not been reassessed and the plan of care reviewed and revised. It was also confirmed that given the number of incidents involving resident #002 the intervention was ineffective.

It is noted that during this time frame medications were being reviewed and revised for resident #002, however while medication doses were titrated, no other nursing measures were initiated to ensure the safety of other residents of the home. [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 ensuring that care set out in the plan of care is provided to the resident as specified in the plan and ensuring that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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 failed to ensure that 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 that minimize the risk of altercations and potentially harmful interactions between and among residents.

On a specified date in 2014 resident #002 was involved in an incident with resident #003, no injury resulted from the incident.

On a specified date in 2014 resident #002 was involved in an incident with resident #001 that resulted in resident #001 sustaining an injury.

Interview and record review confirmed that the first incident involving resident #003 did not result in interventions being initiated to protect other residents.

Interview was unable to confirm that resident #002's actions were reported to oncoming staff and the progress note was not completed until after the end of the shift and after shift report would have been completed. The Director of Care (DOC) and Behaviours Support Ontario Registered Practical Nurse were unaware of the incident of aggression by resident #002 until it was brought to their attention during this inspection.

Interview with the DOC confirmed that if interventions had been initiated at the time of the first incident involving resident #002 they may have prevented the incident that resulted in injury to resident #001. [s. 55. (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 ensuring that 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 that minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

Issued on this 22nd day of July, 2014

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