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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
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
Jan 16, 2018	2017_643111_0021	019625-17, 022144-17	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

PLEASANT MEADOW MANOR
99 Alma Street P. O. Box426 Norwood ON K0L 2V0

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

LYNDA BROWN (111)

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): December 12 & 13, 2017

A follow-up inspection (log # 018545-17) was completed concurrently during this critical incident inspection (see inspection # 2017_643111_0020) related to late reporting of abuse.

A complaint inspection (Log # 018205-17) was completed concurrently during this critical incident inspection (see inspection #2018_643111_0002). The complaint was related to falls with injury. Non-compliance was identified for the complaint and issued under this inspection report.

Two critical incident inspections were also completed:
-(log # 019625-17) related to falls with injury.
-(Log # 022144-17)related to resident to resident abuse. Details regarding this inspection were identified under the follow up inspection. No areas of non-compliance were identified related to this log.

During the course of the inspection, the inspector(s) spoke with the Administrator/DOC, the Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs) , Personal Support Workers (PSWs), Physiotherapist (PT) and residents.

During the course of the inspection, the inspector reviewed a deceased resident's health record current resident health record, reviewed the licensee's Falls Prevention policy, Falls Prevention meeting minutes and licensee investigations.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure the resident, the SDM, if any, and the designate of the resident / SDM had been provided the opportunity to participate fully in the development and implementation of the plan of care.

Related to log # 019625-17:

A critical incident report (CIR) was submitted to the Director on a specified date in 2017 for fall that resulted in an injury. The CIR indicated nine days earlier, at a specified time, resident #001 sustained a fall with injury to a specified area. The resident was transferred to hospital four days later and was diagnosed with an injury to a specified area. The CIR indicated the SDM was upset because they were not notified of the fall until three days later.

Review of the health care record and interview with staff indicated resident #001 sustained a fall on a specified date in 2017 at a specified time. The SDM was contacted by the home the following day regarding a change in condition but was not informed of the fall until three days later. [s. 6. (5)]

2. The licensee has failed to ensure the resident was reassessed and the plan of care was reviewed and revised when the resident's care needs changed.

Related to log # 019625-17:

A critical incident report (CIR) was submitted to the Director on a specified date in 2017 for a fall that occurred nine days earlier at a specified time, resulted in an injury and was transferred to hospital. The CIR indicated resident #001 had an injury to specified areas and was transferred to hospital four days later for assessment and was diagnosed with an injury to a specified area. The CIR was completed by the Administrator/DOC.

Review of the progress notes of resident #001 indicated prior to the fall, the resident walked with a mobility aid with supervision. The resident would frequently forget to use the mobility aid due to cognitive impairment and would walk around the home without the aid. On a specified date in 2017, at a specified time, the resident was found on the floor in a specified area. The resident sustained an injury to a specified area and denied any pain at that time. Treatment was provided to the injury and the resident was placed on head injury routine. The resident remained in bed for the remainder of the shift and the following shift. There was no documented evidence the physician or SDM were notified.
- The following day, the resident had remained in bed for the morning, was then observed up walking at lunch. The resident's health had declined before supper, began demonstrating signs of pain to a different specified area and was returned to bed. At a specified time, was administered a narcotic analgesic, an anti-pyretic and an anti-psychotropic for agitation. The SDM was notified of 'declining health' but not regarding the fall and increased pain. The documentation indicated the resident would be monitored and on-call physician contacted if needed.
-The following day, the resident had remained in bed awake all night and was given an anti-psychotropic for agitation, at a specified time. The resident remained in bed all day and was given a narcotic analgesic twice during the day for pain. During the evening, the resident continued to experience pain to a specified area and had visible signs of serious injury to the area. The on-call physician was contacted and ordered a mobile diagnostic test to rule out an injury to the specified area.

-The following day, the resident continued to remain in bed. The SDM contacted the home for an update on the resident and was informed of the diagnostic test and informed the results had not yet been received. The SDM indicated resident to be sent to hospital if suspected injury. The Nurse Practitioner (NP) was then contacted and indicated if signs of injury, to transfer resident to emergency. The resident was then reassessed in bed with visible signs of injury to a specified area and demonstrated visible signs of pain with movement to the area. A second call was placed to the NP and recommended transfer to hospital. The staff attempted to notify the SDM of transfer to hospital. Approximately forty five minutes later, the resident was administered a narcotic analgesic. Approximately twenty minutes later, 911 was called and the resident was transferred to hospital for assessment. The hospital called the home to confirm the resident had sustained an injury to a specified area, resulting in a significant change in condition.

Interview with the Administrator/DOC indicated the resident was not transferred to hospital until four days later when the resident began complaining of pain and after discussion with physician and the SDM. The Administrator/DOC indicated the on-call physician was contacted two days post fall and ordered a mobile diagnostic test and the results were not received until the following day (four days post fall).

The plan of care was not revised when the resident's care needs changed, after the resident sustained a fall and began demonstrating a significant change in condition as the resident: was confined to bed for 3 days post fall, had new pain to a specified area, resulting in increased use of a narcotic analgesic, had visible signs of serious injury to a specified area, and pyrexia. The physician was not immediately notified and the resident was not transferred to hospital for 3 days post fall and was subsequently diagnosed with a serious injury to a specified area. The resident was also inconsistently re-assessed for pain and only given analgesia four times over a four day period despite visible signs of pain and injury to a specified area. [s. 6. (10) (b)]

3. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised, when the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

Related to log # 018205-17:

Review of the written care plan in place for resident #002 (at time of the falls) indicated: the resident required one staff assistance with all transfers, and used two different

mobility aids but one of them as the primary mode of ambulation. The resident was a high risk for falls related to unsteady gait and history of falls. Interventions included: remind resident to use mobility aid at all times when ambulating and ensure personal alarm on when in bed and when in mobility aid.

Review of the progress notes of resident #002 indicated over a three month period in 2017, the resident sustained five falls. The resident's health was declining during that period of time and becoming more unsteady. The resident subsequently died on a specified date in 2017 (unrelated to the falls). Prior to the first fall, the resident was independently mobile with use of a mobile aid. The resident sustained the first fall on a specified date in 2017 when the resident was walking without the mobility aid and did not sustain any injury. The resident sustained a second fall three days later and sustained a tissue injury to two specified areas. The staff implemented an alarming device and the resident was placed in a different mobility aid. At times, the resident was disorientated and would attempt to self- transfer without the use of mobility aid or staff assistance. The third fall occurred approximately one week later resulting in another tissue injury to a specified area. The SDM requested staff to respond to alarming device immediately. The fourth fall occurred approximately three weeks later, resulting in a tissue injury to specified areas and was placed on head injury routine. The fifth fall occurred six days later, resulting in an abrasion to a specified area. The SDM was very upset as a result of the resident's ongoing falls with injury despite the use of alarming device.

Interview with PSW # 103 & #104 by Inspector #111 both indicated it was difficult trying to respond to resident alarming devices quickly, and usually by the time they get there, the resident has already fallen.

There were no other approaches considered in the revision of the plan when the interventions used (alarming devices) were not effective. [s. 6. (11) (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 the SDM, if any, or the designate of the resident is provided the opportunity to participate fully in the development and implementation of the plan of care; to ensure when the resident is reassessed, the plan of care is reviewed and revised when the resident's care needs change; to ensure when the plan of care has not been effective related to falls, different approaches are considered in the revision of the plan, 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 :

The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Related to log # 018205-17:

Interview with RN #108 and Administrator/DOC both indicated the expectation when a resident falls, the resident is assessed and has a post-fall investigation assessment completed electronically to determine cause of fall, interventions currently in place and interventions to be considered to prevent a recurrence.

Review of the progress notes of resident #002 indicated over a three month period in 2017, the resident sustained five falls, four with injuries to specified areas.

Review of the post fall investigation assessments indicated there was no post fall assessment completed for three of the five falls. [s. 49. (2)]

Issued on this 16th day of January, 2018

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

Original report signed by the inspector.