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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Aug 30, 2016	2016_200148_0028	023018-15, 019837-16, 019663-16, 019726-16 AND 000236-16	Critical Incident System

Licensee/Titulaire de permis

The Governing Council of the Salvation Army in Canada
2 OVERLEA BLVD. TORONTO ON M4H 1P4

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

THE SALVATION ARMY OTTAWA GRACE MANOR
1156 WELLINGTON STREET OTTAWA ON K1Y 2Z3

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

AMANDA NIXON (148)

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): August 8-11, 2016.

This inspection included five critical incident reports, related to continence care, responsive behaviours and fall prevention.

During the course of the inspection, the inspector(s) spoke with the home's Director of Nursing (DON), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition, the Inspector observed a resident's mobilization and physical device use, a resident room as it relates to fall prevention, reviewed health care records, plans of care, physician orders and administration of medications along with resident interactions and resident care and services.

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

During the course of this inspection, Non-Compliances were issued.
- **1 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and other who provided direct care to resident #002.

Resident #002 was observed on the afternoon of August 9, 2016, to be seated in a wheelchair at the nursing station. RPN #101 reported that the resident was removed from the dining room and was fed lunch at the nursing station due to responsive behaviours. At the time of the observation, with the exception of the wheelchair, no physical devices were in use and the resident was calm.

During a review of the resident's health care record related to falls and responsive behaviours the following were found:
- There is a physician order for restraint table top with seat belt for comfort, safety, positioning
- The plan of care indicates that resident #002 wanders on the unit and transfers with use of a walker, that the resident will refuse to use
- The most recent Minimum Data Set (MDS) Assessment indicates the resident ambulates independently
- Progress notes and Risk Management data indicate the resident has had frequent falls, including 12 falls since April 2016.

The plan of care accessible to PSW staff members does not include the purpose or use of a wheelchair, seat belt or table top. In discussion with PSW #100, who identified herself as a regular day shift PSW, it was reported that the resident does not ambulate the unit very much anymore and has been primarily using the wheelchair, she noted that she always applies the seat belt but that the resident can release the belt so it does not necessarily maintain the resident in the chair. She noted the chair and belt are used when the resident is tired and/or when the resident's balance and gait are poor.

The Treatment Administration Record (TAR) indicates that a tabletop and seat belt are used for comfort, safety and positioning as needed. The current physician order reads "restraint table top with seat belt for comfort, safety, positioning". Writer discussed the use of the wheelchair, seat belt and table top with RPN #101, identified as the regular day shift RPN for the unit. RPN #101 reported that the wheelchair was provided to the resident with both the belt and table top, but that staff do not use the table top. She further described that if the resident is agitated or trying to leave the chair they may use the seat belt, if the resident is calm they will not apply the belt.

The plan of care, including the plan that is accessible to the PSW staff, the TAR and physician order, does not set out clear directions to staff as it relates to the use of the wheelchair, table top and seat belt for resident #002.
[s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care for resident #002 was based on an assessment of the resident and the resident's needs and preferences.

Resident #002 is at risk for falls with as it relates to his/her chronic health conditions. During a discussion with RPN #101, it was reported that the resident has been known to have seizure activity, will refuse medication and does not always like to get up in the morning. As described by RPN #101, the late rising of the resident leads to medication holds as she does not administer medications to the resident in bed due to choking risks. Inspector observed the resident on August 10, 2016, whereby the resident remained in bed until at least 1030 hours. PSW #100, noted the resident does not like to get up early in the morning and if woken early this may lead to responsive behaviours, therefore the resident rises on his/her own.

A review of the health care record indicates that a recent physician's order prescribed resident #002 with anti-convulsant drug three times daily, morning, noon and evening. The Inspector reviewed the medication administration records (MARs) over the last

several months. The following was identified:
- 10 doses of the anti-convulsant was held or refused in an identified month
- 14 does of the anti-convulsant drug was held or refused in an identified month
- There was one month identified whereby there were no doses of the anti-convulsant drug held or refused. In discussion of this matter with RPN #101, no change in the resident's condition/status could be identified but RPN #101 did note that different staff were attending to the unit during this identified month.

Progress notes during the months identified support that the anti-convulsant drug was held due to the resident's late rising in the morning and/or refusal of medications during care.

The health care record was reviewed by the Inspector, and at a later time reviewed by the home's ADOC and RPN #101. It was determined that resident #002 had a measure of a clinical indicator related to the use of the anti-convulsant drug. It is suspected that the measurement was prompted due to a fall that occurred in the months reviewed above, which the ADOC noted was potentially related to seizure activity. At the time of the inspection there was no standing order or procedure in place to monitor the identified clinical indicator for this resident. The ADOC indicated to the Inspector that such a clinical indicator would usually be monitored every three months, and given the known pattern of medication administration for this resident, monitoring would be required.

The plan of care was not based on an assessment of the resident and the needs of the resident with respect to the administration and monitoring of an anti-convulsant drug with known refusals/holds of the medication, seizure activity and frequent falls.
[s. 6. (2)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified by the plan.

Resident #002 is at risk for falls. On a specified date, the resident was found on the floor in the resident's bedroom between the bed and window. The fall resulted in injury and significant change to health status.

The plan of care for resident #002's risk of falls, includes the use of a floor alarm and fall mat. The floor alarm is to be placed on the side where the fall mat is located when the resident is in bed. The fall mat is to be placed on the side of the bed closest to the window as this is where falls occur.

On the morning of August 10, 2016, Inspector #148 observed the resident in bed sleeping. The fall mat was observed to be placed on the floor on the left side of the bed nearest the door. On initial observation the Inspector could not see a floor alarm in use. It was discovered that the floor alarm was on the top of a dresser at the bedside and in the off position. The Inspector approached PSW #100, who came to the room and placed the alarm on the floor on the side of the bed nearest the window. No attempt was made to move the floor mat. Upon questioning, PSW #100 reported that the resident tends to get up on the side of the bed nearest the window and this is why the alarm was placed on this side. When discussing the floor mat, the PSW noted that the resident can be unpredictable and that may be why the floor mat is on the opposite side.

On August 10, 2016, the care set out in the plan of care for resident #002 as it relates to the use of a fall mat and floor alarm where not provided as specified in the plan.
[s. 6. (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 plan of care sets out clear directions to staff, is based on an assessment of the resident and is provided as specified by the plan, to be implemented voluntarily.

Issued on this 30th day of August, 2016

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

Original report signed by the inspector.