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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2013	2013_198117_0017	000446 + 3	Critical Incident System

Licensee/Titulaire de permis

peopleCare Not-For-Profit Inc
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

LYNE DUCHESNE (117)

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): September 4, 5 and 6, 2013

It is noted that 4 critical incident inspections were conducted during this inspection : Logs # O-000438-13, #O-000446-13, #O-000619-13 and #O-000669-13

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, Director of Care (DOC), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), a housekeeping aide and several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents, examined lunch time meal services of September 4, 5 and 6 with a focus on responsive behaviours during meal services, examined the rooms of several identified residents with a focus on fall prevention interventions and examined an identified resident's wheelchair.

The following Inspection Protocols were used during this inspection:
Falls Prevention

Medication

Personal Support Services

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. (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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA s. 6 (1) (c) in that a resident's plan of care did not set out clear direction to staff and others who provide direct care to the resident. [Log #O-000438-13]

Resident #4 mobilizes with the aid of a wheelchair. On a specified day in May 2013, staff member S#101 was taking Resident #4 from the unit dining room to the unit lounge area for a music program. During the transportation, Resident #4 yelled out in pain. The staff member S#101 stopped and noted that Resident #4's foot was caught behind one of the wheelchair's front wheels. It was noted that the wheelchair foot rests were not in place at the time of the incident. Resident #4's foot was assessed by the unit RPN and RN. Some redness to the foot and discomfort at movement were initially noted. Swelling, bruising and increased pain were later noted and the resident was transferred to hospital for further assessment. Resident #4 was diagnosed with an injury the foot.

Resident #4's March 2013 plan of care, in place at the time of the injury, identifies that the resident is dependent on one person assistance to move to other areas of the resident care unit and facility. It does not identify the need to have wheelchair foot pedals in place to ensure safe transfers and transportation on and off the resident care unit. On September 6, 2013, interviewed staff members S#102 and S#103 told Inspector #117 that the resident did have wheelchair foot rests but that these were not consistently applied to the resident's wheelchair as the resident frequently used his/her feet to self propel on the unit. This was also not identified in the resident's March 2013 plan of care.

Resident #4's plan of care did not set out clear direction to staff regarding the use of wheelchair foot rests during transfers and transportation, nor did it identify that the resident could use his/her feet to self propel on the unit. [s. 6. (1) (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 to ensure that Resident #4's plan of care gives clear director to staff in regards to the use of wheelchair foot rests for transfers and transportation as well as give clear direction regarding Resident #4's ability to self propel when in seated in a wheelchair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s, 26 (3) 5 in that an identified resident does not have a responsive behaviour plan of care based on an interdisciplinary assessed of their mood and behaviours patterns, identified responsive behaviours, potential behavioural triggers and variations in resident functioning at different times of the day. [Log # O-000446-13]

Resident #1 is identified as having cognitive impairments. On a specified day in May 2013, Resident #1 was seated at a dining table waiting for his/her lunch time meal service. Resident #2 was seated beside Resident #1. Staff member S#104 prepared Resident #2's lunch time medication which included an anticonvulsant medication mixed in juice. The staff member S#104 went to Resident #2, placed the glass of orange juice mixed with the prescribed anticonvulsant medication, on the dining table at his/her side. The staff member S#104 then proceeded to give Resident #2's other oral medication that were mixed in applesauce.

Resident #1 reached out across the dining table and grabbed the orange juice - medication mixture from the staff member's side. He/She proceeded to drink most of the orange juice medication mixture. Staff member S#104 noticed Resident #1's actions and stopped him/her from drinking all of the orange juice medication mixture. Resident #1 was immediately assessed by the unit RPN and RN. The attending physician and Resident #'1 POA were notified of the medication incident. Resident #1 was sent to hospital for further assessment and returned to the home later that same day.

Unit staff members S#105, S#108, S#106 and S#107 stated to Inspector #117 on September 4 and 5, 2013, that Resident #1 does have occasional responsive behaviours during meal services. They all report that Resident #1 can become very agitated during a meal service and start reaching out, grabbing and eating other resident table mates meals and beverages. Resident #1 is also reported to throw his/her and other residents utensils and glassware across the dining table, making his/her table mates very upset. The staff members state that when this occurs, Resident #1 is moved to another table and seated beside Resident #2 who is very quiet and requires 1 staff assistance with meal services. They stated that this helps in managing Resident #1's food / beverage grabbing, throwing and eating behaviours.

On September 5, 2013, the DOC stated that in May 2013, staff member S#104 was new to the home. The DOC stated that on the specified day in May 2013, staff

member S#104 was also new to working on the identified resident care unit and was not aware of Resident #1's behaviours of grabbing and eating of other resident's food and beverages during the meal service. The staff member was not aware of these behaviours when he/she put down the glass of orange juice - anticonvulsant mixture on the dining table, at his/her side, when he/she administered Resident #2's other medication.

Resident #1's plan of care, in place at the time of the incident in May 2013 and still currently in place, does not identify any responsive behaviours linked to Resident #1 grabbing , eating and drinking of other residents food and beverages. It does not identify potential triggers for these meal time behaviours. It also does not identify interventions related to the resident being moved to another table, to decreased disruptive meal service behaviours. [s. 26. (3) 5.]

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 Resident #1's responsive behaviours and related interventions are clearly identified in the resident's plan of care, to be implemented voluntarily.

Issued on this 13th day of September, 2013

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

Lynn Duchesne #117