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
Dec 18, 2013	2013_230134_0023	001045, 001126-13	Complaint

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 11, 12 and 13, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPN), Personal Support Workers, Resident #1 and a Substitute Decision Maker (SDM).

During the course of the inspection, the inspector(s) reviewed the resident's health records including; progress notes, medication administration records (MARS), vital sign sheet, the Head Injury Routine form, the Fall Prevention and Management Policy #F23 and the critical incident report.

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

1. The licensee failed to comply with the LTCHA, 2007 S.O. chapter.8 s.6 (11) (b), in

that different approaches were not considered when Resident #1's plan of care was revised when the care set out in the plan was not effective.

On a specified day in October, 2013, Resident #1 had an unwitnessed fall in his/her room. At the time of the fall the resident was assessed and observed to be visibly shaken with a high blood pressure.

There is an entry in the progress notes on a specified day in October, 2013, indicating Resident #1 complained of pain under left hand and left armpit at 01:53. An analgesic was administered but was not effective in managing the pain.

There is an entry on a specified day in October, 2013 indicating Resident #1 was administered an analgesic for shoulder pain, following the fall, which was partially effective. Resident was awake on further checks and complained of pain.

There is an entry in the progress notes on a specified day in October, 2013 indicating that the nurse spoke with the resident regarding complaints of shoulder pain. The Resident verbalized that he/she is not in constant pain, but it hurts once in a while. The nurse mentioned that an x-ray should be ordered. the nurse attempted a few times to reach the physician with no success.

There is an entry in the progress notes on a specified day in October, 2013 indicating the resident's blood pressure was high on two occasions. These readings were higher than the resident's normal range.

There is an entry made on a specified day in October, 2013 indicating the resident is complaining of shaking. "He/She reports that his/her body was shaking in trunk and head. Resident reports that shaking began after a fall the other night. Shaking can be seen when lying down".

The unit nurse was interviewed by the inspector December 12, 2013, and indicated that no return call was received from the attending physician on a specified day in October, 2013 and that no follow-up was done with the on-call physician. An X-ray was not ordered as was suggested by the unit nurse. The unit nurse reported the resident was not herself after the fall and was seen shaking and was less active, which was unusual for this resident.

The Fall Prevention Policy #F23 was reviewed and there is an entry on page 6 that

stipulates to notify the attending physician of the fall, interventions and status of the resident.

There is an entry on a specified day in October, 2013 indicating the resident was administered an anti-emetic to aid nausea. The MARS were reviewed for the months of September to November 2013 and there are no other entries to indicate a history of nausea.

The resident's condition was changing after the fall, which included fluctuating blood pressure, increased pain in shoulders, armpit and left hand, unrelieved pain when medicated, nausea, body shakiness and anxiety. There are no indication that these changes were reported to the physician, no x-ray was ordered to rule out any fracture and the resident was not sent to hospital for assessment following the complaints of increased pain in shoulders.

The resident was transferred to hospital on a specified day in October, 2013 after complaints of chest pain and shakiness, where she was diagnosed with fractures.

As such, different approaches were not considered in a timely manner when Resident #1's care set out in the plan of care was not effective after a fall he/she sustained on a specified day in October, 2013. [s. 6. (11) (b)]

Issued on this 20th day of December, 2013

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

Colette Asselin, LTCH Inspector #134