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 # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2016	2016_347197_0016	014959-16	Complaint

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 BROCKVILLE ON K6V 5T1

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

ST. LAWRENCE LODGE
1803 County Road, #2 East Postal Bag #1130 BROCKVILLE ON K6V 5T1

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

JESSICA PATTISON (197)

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): June 17, 20, 21, 2016

Three complaint logs were completed as part of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, an Assistant Director of Care, a Physician, Registered Nurses, a Registered Practical Nurse, Personal Support Workers, a staff member from the business office, residents and resident family members.

The inspector also reviewed resident health care records, policies and procedures related to staffing and falls, a resident's financial statements, a letter of concern from a family member and observed resident care.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Hospitalization and Change in Condition
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. (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 has failed to ensure that when resident #001 was reassessed and the plan of care was revised because care set out in the plan had not been effective, different approaches were not considered in the revision of the plan.

On a specified date, resident #001 had a fall. A post-fall assessment was completed with no major concerns.

A review of the progress notes showed that after the time of the fall the resident complained of pain and was transferred at times with a mechanical lift. The resident was assessed three days after the fall by a Nurse Practitioner who noted some pain and ordered warm packs for the resident. After this assessment, the resident continued to show signs of pain and the Physician was called seven days after the fall and an order was received for an as needed (PRN) pain medication. Resident #001 continued to show signs of pain for another five days after the PRN pain medication was ordered and was sent out to hospital at the request of the family twelve days after the resident fell. The resident returned to the home later that day with a diagnosed fracture.

Staff interviews were conducted with five Personal Support Workers (PSW), one Registered Practical Nurse (RPN), four Registered Nurses (RN) and the resident's Physician on June 20/21, 2016.

The five PSW's all indicated that the resident continually expressed pain after the fall and noted other changes in the resident's condition. All stated that they reported the resident's pain and changes in condition to registered staff.

An RPN indicated that she had not worked during the time between when the resident fell and when they were sent to hospital but confirmed that she had heard from other staff that the resident was in pain and she stated it was not like the resident to voice pain.

Three of the four RN's interviewed had assessed resident #001 at different times after the fall and before the resident was sent to hospital. All stated that when they assessed the resident, they did not feel at the time that the resident needed to be sent to hospital. Two of the RN's also indicated that the resident was difficult to assess due to his/her diagnosis. One RN indicated that a PRN (as needed) order was received for a pain medication to help with the resident's pain but was not effective. She stated it would help at first but did not give the resident long periods of relief.

During an interview with the resident's Physician, he indicated that he felt the resident's fracture went undiagnosed due to his/her diagnosis. He said he read the Nurse Practitioner's assessment three days after the fall and did not note any concerns. When asked, he stated that he felt the resident's fracture was likely caused by the fall.

In summary, resident #001 fell on a specified date. The resident was noted to have increased pain requiring the addition of a PRN (as needed) pain medication seven days after the fall, which was noted by one RN to be ineffective at treating the resident's pain. PSW's working with the resident indicated that he/she was experiencing pain and noted other changes in his/her condition. The resident was sent out to hospital 12 days after the fall at the request of a family member and was diagnosed with a fracture. The resident was not seen by a Physician or Nurse Practitioner for a nine day period before being sent to hospital. When care set out in the plan of care for resident #001 was not effective, different approaches were not considered in the revision of the plan. [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 that when a resident is exhibiting pain and care set out in the plan of care has not been effective, that different approaches are considered in the revision of the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a bed alarm in the home was not maintained in a good state of repair.

On a specified date, resident #001 fell from bed. The resident had a bed alarm in place at the time of the fall, but the alarm did not sound. RN #111 indicated in an interview that she checked the bed alarm after the resident fell and noted that the adapter that plugged into the call bell system had malfunctioned. She stated that this piece was changed and the bed alarm was then functional.

On June 21, 2016 at approximately 1100 hours, Inspector #197 tested resident #001's call bell/bed alarm and noted that it would not activate. RPN #107 was in the hallway and was asked to come test the call bell/bed alarm. She also could not get the bed alarm or call bell to sound. The RPN said they have had issues with these adapters in the past and indicated she would go call maintenance immediately to have it repaired.

At the time of resident #001's fall and during the inspection period, resident #001's bed alarm adapter that plugs into the call bell system was noted to be in disrepair. [s. 15. (2) (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 bed alarms are maintained in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that an incident that caused an injury to resident #001 for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition, was not reported to the Director as required.

"Significant change" is defined in the regulations as:
A major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

On a specified date, resident #001 fell and sustained an injury.
The following day, the resident was noted in the progress notes to have pain. The resident was assessed by the Nurse Practitioner three days after the fall and was noted to have pain and ordered a treatment for the pain.
For an 8 day period after the fall, the progress notes indicate the resident continued to complain of pain and the resident was sent out to hospital for assessment 12 days after the fall at the request of the resident's family member. The resident was sent back to the home later that day with a diagnosis of a fracture. Changes were made to resident #001's plan of care upon return to the home.

During an interview with the Director of Care on June 21, 2016, she stated that she had not reported to the Director the injury of resident #001 for which the resident was sent to hospital and that resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

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 all incidents that cause an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health condition, is reported to the Director as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of resident #001 was immediately forwarded to the Director.

On a specified date, a family member of resident #001 submitted a written letter to the Administrator of the home outlining concerns and recommendations regarding the care of a resident.

During a telephone interview on June 22, 2016, the Administrator indicated that he did not forward this written letter concerning the care of a resident to the Director. [s. 22. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response was made to the family member of resident #001, who made a written complaint concerning the care of the resident.

On a specified date, a family member of resident #001 submitted a written letter to the Administrator outlining concerns and recommendations for change regarding the care of a resident.

During a telephone interview with resident #001's family member, he/she indicated that a response had not been received related to the letter that was given to the home with concerns and recommendations.

During an interview with the Administrator on June 20, 2016, he provided a copy of the written letter received from the family member of resident #001 and confirmed that a response had not been made to this letter. [s. 101. (1) 3.]

Issued on this 27th day of June, 2016

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

Original report signed by the inspector.