Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Jun 20, 2016	2016_288549_0015	013515-15, 015285-15, 000130-16	Critical Incident System

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

RENA BOWEN (549)

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): June 14, 15, 16, 2016.

Log # 013515-15 and 015285-15 are related to Fall Prevention
Log # 000130-16 is related to Prevention of Abuse and Neglect

During the course of the inspection, the inspector(s) spoke with residents, a family member, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Assistant Director of Care (3rd floor) and the Director of Care.

At the time of the inspection the inspector reviewed resident health care files, the Restraint/Repositioning Flow Sheet, resident/staff communication system response report, staff schedule, staff training records, the home's abuse investigation documentation, the home's Abuse and Neglect of Residents policy, number 0202-02-05, last reviewed January 2015, the Transfer and Lifts policy, number 0401-03-10, last reviewed January 2016, the Fall Prevention Program policy, number 0401-03-78, last reviewed January 2016, Fall Risk Assessment policy, number 0401-05-51, the Fall Follow-Up policy, number 0401-03-15, last reviewed January 2016, the Restraint/PSAD Use policy, number 0401-05-09, last reviewed January 2016 and the Restraint Minimization policy, number 0401-05-12, last reviewed January 2016.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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 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 failed to ensure that the Director is informed of the following no later than one business day after the occurrence of the incident, followed by the report under subsection (4): Subject to subsection(3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's condition.

The home submitted a Critical Incident Report on a specific day in June 2015 indicating that on a specific day in May 2015, a bed alarm sounded on the unit alerting the staff. The staff found resident #002 at then end of the resident's bed lying on the floor.

Resident #002 was assessed by the registered staff and then transferred to hospital.

Resident #002 had an unwitnessed fall on a specific day in May 2015. The resident was transferred to hospital and admitted with a fracture. The home was notified of the significant change in the resident's condition on a specific day in May 2015 by resident #002's Substitute Decision Maker.

The home notified the Director on a specific day in June 2015, which is four business days following the occurrence of the incident for which the resident was taken to a hospital and that resulted in a significant change in the resident's heath condition. [s. 107. (3) 4.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident’s response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, specifically: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident’s response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #001 was admitted to the home on a specific day in March 2015. The Minimum Data Set Assessment (MDS) completed on a specific day in June 2015 indicated that resident #001 is severely cognitively impaired with a Cognitive Performance Scale score of 5. The MDS also indicated that the resident is a one person assist for mobility and a two person assist for transfers. The Fall Risk Assessment completed on a specific day in June 2015 indicated the resident to be at a high risk for falls.

During an interview on June 14, 2016, PSW #100 indicated that due to the resident's cognitive impairment the resident would forget to ask or wait for assistance to transfer or walk.

On a specific day in June 2015 resident #001 had a fall and sustained a fracture which required a surgical repair. The resident returned back to the home on a specific day in June 2015 after the surgical repair.

Resident #001 was assessed on a specific day in June 2015 as part of the home's Fall Prevention Program. The assessment concluded that resident #001 required a restraint for safety. The Fall Risk Assessment indicated that the resident was at a high risk for falls and due to the residents cognitive impairment may attempt to walk on own. A physician's order was obtained along with the written consent of the Substitute Decision Maker.

The home's Restraint Minimization policy # 0401-05-09 last reviewed January 2016 indicates on page four the following: Restraint Flow Sheet must be completed each shift by the RN, RPN, and/or Nursing Attendant. Document:
1. Every 60 minutes while the resident is awake or more frequently as required, or as indicated on the plan of care.
2. Removal of restraint every 2 hours for repositioning/ambulation.
3. Reassessment every 8 hours that through the resident's response is tolerating the restraint is effective and continues to be required. Any adverse effects should be documented on the progress notes including interventions and required follow-up.

During an interview on June 16, 2016, the Director of Care (DOC) indicated to Inspector #549 that the PSWs are responsible for documenting the monitoring every hour, release and removal of the restraint and the repositioning of the resident every 2 hours. The DOC also indicated during the same interview that the registered staff are responsible for documenting the assessment and reassessment every 8 hours through the resident's response whether the resident is tolerating the restraint; the restraint is effective and continues to be required. The tool the home using for documenting restraints is titled the Restraint/Positioning Flow Sheet.

Inspector #549 reviewed residents #001's Restraint/Positioning Flow Sheets for June, July and August 2015.

There is no documentation related to monitoring, release, repositioning, removal or

application of the restraint on the Restraint/Repositioning Flow Sheet on the following days:

On a specific day in June 2015 between 1500 hours and 2300 hours , on three specific days in June 2015 between 0700 hours and 2300 hours, on a specific day in June 2015 between 0700 hours and 2200 hours.

On a specific day in July 2015 between 1500 hours and 2200 hours, on a specific day in July 2015 between 0800 hours and 2300 hours, on a specific day in July 2015 between 0800 hours and 1400 hours, on a specific day in July 2015 between 0800 hours and 2300 hours, on four specific days in July 2015 between 1500 hours and 2300 hours, on a specific day in July 2015 between 0000 hours and 0700 hours, on a specific day in July 2015 between 0700 hours and 2300 hours.

On three specific days in August 2015 between 0700 hours and 2300 hours, on four specific days in August 2015 between 1600 hours and 2300 hours, on two specific days in August 2015 between 1500 hours and 2300 hours, on a specific day in August 2015 between 0000 hours and 0600 hours and between 2100 hours and 2300 between, on a specific day in August 2015 between 2100 hours and 2300 hours.

There is no documentation of the assessment and reassessment, including the resident's response to the restraint on the Restraint/Repositioning Flow Sheet by the registered staff for 23 shifts in June, 6 shifts in July and 16 shifts in August 2015.

The DOC indicated to Inspector #549 on June 16, 2016 during an interview that the home's expectation is that the documentation on the Restraint/Repositioning Flow Sheet for resident #001 be completed every shift. Indicating the monitoring, release, repositioning, removal or application of the restraint and the assessment and reassessment, including resident #001's response to the restraint.

In summary the licensee failed to ensure that the person who applied resident #001's restraint, all assessments, reassessments and monitoring, including resident #001's response, every release of the restraint including the removal of the restraint was documented every day in June, July and August 2015. [s. 110. (7)]

Issued on this 20th day of June, 2016

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

Original report signed by the inspector.