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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 9, 2019	2019_702197_0020	012016-19, 013369-19	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): August 19 - 22, 26-28, 2019

The following complaints were inspected as part of this report:

Log 012016-19 - a complaint related to resident assessment, falls prevention, staffing and dealing with complaints.
Log 013369-19 - a complaint related to resident assessment and hydration.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, two Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Staffing personnel, the Registered Dietitian, residents and their family members.

The inspector also reviewed resident health care records, policies and procedures related to falls prevention, head injury routine and hydration, and observed resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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	Légende 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Head Injury Routine procedure was complied with for residents #001 and #002 when implemented as part of the licensee's Fall Prevention Program and Fall Follow-Up process.

O. Reg. 79/10, s. 48 (1) states that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The Director of Care (DOC) provided a copy of the licensee's Fall Prevention Program, Fall Follow-Up and Head Injury Routine (HIR) Procedures.

During an interview, the DOC indicated that the HIR Procedure, 0401-05-06, should be followed during the Fall Follow-Up procedure if a resident has an actual or suspected head injury.

The licensee's HIR Procedure stated that the purpose is to monitor for indications of impending problems following a head injury in order to ensure prompt and appropriate intervention.

Forms used include the following:
- Head Injury Monitoring Tool (0401-05-056(a))
- Resident Progress Notes

Step 2 of the HIR procedure indicated that unless otherwise ordered by the physician, institute assessment protocol as follows:
a) q15 minutes x 2. If stable, then
b) q30 minutes x 2. If stable, then
c) q60 minutes x 2. If stable, then
d) q shift x 3.

Step 3 of the procedure indicated that documentation shall include:
a) Progress note entries indicating any changes in any of the above indicators.
b) Monitoring tool entries after review by the physician will become a part of the resident's progress notes.

Resident #001 had a fall on a specified date and was noted to have an head injury. Upon review of the resident's health care record, the Head Injury Monitoring Tool was found and the inspector noted that the second 60 minute check was not documented and there was nothing in the progress notes to indicate this check was completed.

Resident #001 was noted by staff to be falling asleep often throughout breakfast the following morning and not smiling when spoken to as usual. After consulting with the resident's Power of Attorney (POA) for care, the resident was sent to hospital for further assessment. [s. 8. (1)]

2. On a specified date, resident #002 fell and was found on their back beside their bed. At the time of the fall follow-up assessment, there was no noted head injury.

The following day, RPN #103 charted that the resident had a bruise on their head.

Interviews with RPN #103 and the DOC indicated that the process in the home would be to complete the HIR if staff suspected the resident had hit their head and both indicated that when the bruising showed up on resident #002, it was suspected that they had sustained a head injury.

When looking for the HIR monitoring tool, it could not be found and there was no indication in the progress notes that it had been completed as per the licensee's HIR procedure outlined above.

3. On another date, resident #002 fell and was noted to have a head injury and HIR was noted to be initiated at the time.

Upon review of the HIR monitoring tool, it was noted that the first 30 minute check and the second 60 minute check were not documented on the sheet or in the progress notes to indicate they were completed as per the licensee's procedure.

Therefore, on three separate occasions for residents #001 and #002, the licensee did not ensure that their HIR procedure was followed when a resident fell and hit their head or was suspected to have hit their head. [s. 8. (1) (a),s. 8. (1) (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 has fallen and is suspected to have a head injury, that the Head Injury Routine procedure is complied with as part of the licensee's Fall Prevention Program and Fall Follow-Up procedure, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that interventions to mitigate and manage identified risks related to hydration for resident #002 were implemented.

The purpose of the licensee's Hydration Policy # 0401-03-76 is to ensure that residents receive adequate amounts of fluid daily in order to minimize the risk of dehydration. Procedure items 5) - 8) specifically indicate that fluid intake is to be noted on the Resident Care Flow Sheet and that intake of less than 50% is to be reported to the RN for assessment and possible follow up. Fluid intake of less that 50% in excess of 24 hours will necessitate intake/output be recorded.

The Resident Care Flow Sheet for a specified week for resident #002 was reviewed for fluid intake and it was noted that the resident consumed anywhere from 0-75% of their fluids, with 3 refusals and 2 zeros documented. Most days the resident was identified as consuming 50% or less of the fluids provided.

A progress note written on a date in the specified week by ADOC #101 stated that resident #002 was provided with a large glass of juice and informed they needed to drink

to stay hydrated and to help them feel better. The resident was noted to drink the full glass, as well as another full glass of milk at snack pass. PSWs were noted to be informed to ensure that resident #002 was being given drinks with juice pass, as the resident will say no if asked. The note stated that follow-up with resident #002 is needed since they will not drink without cueing and tends to fall asleep. An intake sheet was noted to be started at this time.

Inspector noted an Intake and Output Worksheet dated the same day as above in the resident's chart but only the day shift had documentation under the "in" column and no total was calculated. There was nothing documented in the "out" column for any shift. There were no further Intake and Output worksheets completed in the following days and no related progress notes.

During an interview with ADOC #101, they stated that they implemented the Intake and Output Worksheet due to the resident's poor fluid intake and risk for dehydration. They indicated that the expectation was for staff to continue documentation for multiple days. The ADOC stated that they communicated the use of the worksheets to staff on the day shift, made the progress note and left the worksheet at the desk for staff to complete. The ADOC indicated they also looked and could not find any further worksheets and acknowledged that the staff did not complete the worksheet that was initiated.

Intake/Output Procedure #0401-03-22 stated that the purpose of the procedure is to assess concerns regarding fluid intake and urinary output. Step #3 of the procedure indicates that all staff are responsible to record any fluids provided and all output is measured. Step #5 indicates that a new Intake and Output worksheet is started each morning at 0700 hours. The worksheet for the previous 24 hours is to be filed on the resident's chart with the progress notes.

PSW #104 was interviewed as they had worked the day shift when the Intake and Output worksheet was initiated for resident #002. They indicated that they vaguely remembered ADOC #101 telling the staff to push fluids and recalled that it went well. They stated that when Intake and Output sheets are initiated they are put on a clipboard on the desk at the nursing station, but indicated they did not remember seeing the worksheet for resident #002.

The licensee did not ensure that the Intake and Output worksheet, an intervention to mitigate and manage identified risks related to hydration, was implemented for resident #002. [s. 68. (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 interventions are implemented to mitigate and manage identified risks related to hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002's call bell could be easily seen, accessed and used.

On a specified date, resident #002 was observed in their room on the right side of the bed by the window. At the time of observation, the resident's call bell was wrapped around the lowered bed rail and resting on the floor on the left side of the bed.

Therefore, resident #002's call bell could not be easily seen, accessed and used by resident at the time of observation. [s. 17. (1) (a)]

WN #4: 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 the Director was informed no later than one business day after the occurrence of an incident that caused an injury to resident #001 that resulted in a significant change in their health condition and for which the resident was taken to the hospital.

On a specified date, resident #001 fell and indicated pain during the post-fall assessment. The resident continued to be assessed over the following few days and was noted to experience increased pain and their transfer status was changed. On a later date, resident #001 was transferred to the hospital for further assessment. That day, the home was informed that the resident had sustained a specified injury and would remain in hospital for surgical intervention.

Resident #001 was readmitted to the home approximately 4 days later with multiple specified revisions to their plan of care.

The inspector reviewed the Critical Incident System but was unable to locate a Critical Incident Report related to the fall and significant change in health condition for resident #001.

During interviews with the DOC and ADOC #102, both confirmed that the licensee did not inform the Director of the above incident. [s. 107. (3) 4.]

Issued on this 16th day of September, 2019

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

Original report signed by the inspector.