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
Dec 13, 2016	2016_435621_0017	014716-16, 015935-16, 022795-16, 025248-16, 029542-16, 029645-16, 029742-16, 030936-16, 031316-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET THUNDER BAY ON P7E 1J2

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

JULIE KUORIKOSKI (621), KATHERINE BARCA (625)

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): October 24 - 28, 2016.

Complaint inspection #2016_435621_0016 and Follow Up inspection #2016_435621_0015 were conducted concurrently with this inspection.

Logs that were inspected include:
Six intakes related to critical incidents the home submitted regarding allegations of staff to resident abuse;
One intake related to a critical incident the home submitted regarding allegations of resident to resident abuse; and
Two intakes related to critical incidents the home submitted regarding resident falls.

A finding of non-compliance related to LTCHA, s.6(1)(c), found during this inspection was issued under Follow Up report #2016_425621_0015.

An additional inspector, Debbie Warpula (577) was also present and took part in this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director's of Care (ADOCs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also reviewed resident health records, the home's policies and procedures, employee files, employee training records and the home's investigation files. Inspectors also completed observations of residents, observed the provision of care and services to residents, and observed resident and staff interactions.

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

During the course of this inspection, Non-Compliances were issued.

3 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director on a specific day in October 2016, concerning a fall which resulted in injury to resident #008.

Inspector #577 reviewed resident #008's progress notes which revealed a specific number of the falls which occurred during at a certain time of the day.

During a record review of physiotherapy assessments, the Inspector found that resident #008 was at risk for falling and this had increased since the resident's admission.

The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator #114 provided Inspector #577 with the resident's care plan that was in effect at time of the fall which occurred in October 2016. The Inspector reviewed the care plan, last updated June 2016, and identified that there were no interventions identified to minimize the risk of this resident falling at the certain time of the day.

During an interview with PSW #114 on a specific day in October 2016, they reported that resident #008 required a specific amount of transfer assistance in order to complete a specified activity. PSW #114 reported further interventions which included the resident being supported by staff with a specific activity at specific times throughout the day, and

that the resident had specific safety devices in place to alert staff should they attempt to complete the specified activity themselves.

During an interview with RPN #108, they reported to the Inspector that the registered staff were responsible for updating resident care plans based on resident needs.

During an interview with RAI Coordinator #113 and RPN #108 on a specific day in October 2016, they both confirmed that there were no further revisions to the care plan related a specific care focus after a certain date in June 2016, for resident #008.

During an interview with ADOC #111 on a specific day in October 2016, they confirmed to the Inspector that resident #008's care plan had not been revised to reflect the resident's change in needs related to falls. ADOC #111 identified that there should have been an intervention in place in relation to when this resident was left to complete a certain activity on their own. ADOC #111 further confirmed that a specific intervention in the care plan should have indicated that the resident was non-compliant with asking for assistance and would attempt to complete the activity themselves. [s. 6. (10) (b)] (621)

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 #008 is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Inspector #577 reviewed a CIS report that was submitted to the Director on a specified day in October 2016, for a fall where resident #008 sustained an injury.

Inspector #577 reviewed resident #008's progress notes and found that the resident had a specific number of falls occur between December 2015, and October 2016.

A review of the home's policy titled, "Fall Prevention and Injury Reduction - CARE5-010.02", last revised August 31, 2016, indicated that for all falls, a clinical assessment was to be completed and documented. Additionally, a review of the home's policy titled "Fall Prevention and Injury Reduction - CARE5-P10", last revised August 31, 2016, indicated that residents would be assessed and treated using a post-fall assessment.

A review of documentation for resident #008 revealed inconsistencies with the post fall assessments. The resident did not have a post fall assessment completed using a clinical instrument for a specified number of falls which occurred in April and June 2016.

During an interview with ADOC #111 and DOC #100 on a specific day in October 2016, they both confirmed to the Inspector that the home's electronic post fall assessment was the home's clinical tool. They reported that the home's fall prevention policy referred to this assessment tool as a "clinical assessment" and a "post fall assessment". They further reported to the Inspector that staff were required to complete this tool after every resident fall.

During an interview with ADOC #111 on a specific day in October 2016, they confirmed with Inspector #577 that the electronic post fall was not completed on a specific days in April and June 2016, and should have been completed after every fall. [s. 49. (2)] (621)

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 resident #008 has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

On a specific day in October 2016, resident #017 approached Inspector #625 at a specified time and stated that they had pain in a certain part of their body. PSW #102 was present and stated that the floor did not have an RPN on at that time and proceeded to contact RN #116 and RPN #117. Inspector #625 observed resident #017 over a specific period of time and noted that no pain medication had been administered to them. Inspector continued to observe the resident and, at another specific time, Inspector #625 spoke to resident #017, who confirmed that they still had pain in a certain part of their body and they had not yet been seen by a nurse.

Inspector #625 then interviewed RN #116, who stated that they were aware of resident #017's pain, and that RPN #117 had been notified of the request. RN #116 stated that RPN #117 was covering administration of medication for half of that floor but had not yet attended the floor to complete the medication pass as they were still on another floor, and that ADOC #111 had been notified.

Inspector #625 then observed RPN #117 on another floor. RPN #117 stated that they were giving out medications on that floor before attending to the medication needs of the residents assigned to them on the other floor. RPN #117 also stated that ADOC #111 had given them direction to report to the other floor within a specified time frame in order to administer medication for a particular medication pass.

At a later time, Inspector #621 observed RPN #117 on the floor where resident #017 resided and observed RPN #117 state to RN #116 that they still had a specific number of residents to administer medications to on the floor.

During multiple interviews with Inspector #621 between a specified time frame, RPN #117 stated that they had notified RN #116 that a certain number of residents on the floor had still not received a certain medication or a specific diagnostic test. RPN #117 told the Inspector they had started the medication pass on the floor at a specified time and that they were aware of resident #017's complaints of pain and had provided the resident with medication an hour after arriving on the floor.

During an interview with Inspector #625 on the same day in October 2016, ADOC #111 stated that residents #016 and #018 did not receive their medication as ordered. Consequently the physician had been contacted and an order had been obtained to hold the medication.

A CIS report for the incident was submitted to the Director later the same day by the home identifying the medication incidents where residents #016 and #018 were not administered their medications which required the physician to be called for orders. The report also indicated that resident #019 did not receive their scheduled medication on time for management of their medical condition.

Inspector #625 reviewed subsequent documentation by the home regarding this incident and its impact for resident's #016, #017 and #018.

Inspector #625 reviewed the home's policy "Medication Administration – CARE13-010-01" effective August 31, 2016, which indicated that scheduled medications were to be administered according to standard medication administration times.

During an interview with resident #016 on a specific day in October 2016, they confirmed to the Inspector that they had not received their medication during the time of the incident

on the specific day in October 2016.

During an Interview with ADOC #111, they stated to Inspector #625 that on the specific day in October 2016, they identified a certain number of residents on the floor where the incident occurred, were not given their prescribed medications on time. [s. 131. (2)] (625)

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 drugs are administered to residents #016, #017, #018, #019 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 3rd day of January, 2017

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

Original report signed by the inspector.