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
Aug 8, 2014	2014_294555_0016	O-000280-13,O-000425-13	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF THE CITY OF KAWARTHA LAKES
26 Francis Streeet, LINDSAY, ON, K9V-5R8

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

VICTORIA MANOR HOME FOR THE AGED
220 ANGELINE STREET SOUTH, LINDSAY, ON, K9V-4R2

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

GWEN COLES (555)

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): July 14, 15, 16, and 17, 2014

This inspection was conducted regarding three Critical Incident Logs #O-000280 -13, #O-000425-13, and #O-000594-13.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Risk Management RN, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) interviewed staff, reviewed clinical records, observed a resident, reviewed incident reports, College of Nurses of Ontario Standard - Medication and seven policies.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 ensure that the written plan of care for Resident #2 sets out the planned care for the resident related to falls and therapeutic treatment.

Related to Log# O-000594-13:

On a specified date Resident #2 sustained an unwitnessed fall resulting in no injuries. Review of clinical notes indicated that Resident #2 was to have an alerting device in place but was not applied.

Approximately one month later Resident #2 was again found to have fallen with no apparent injury noted. Review of clinical notes indicated that the alerting device was broken and not in place.

Review of the plan of care for Resident #2 found no documented evidence related to alerting device and hi/lo bed. Interview conducted with the ADOC who reported was aware that Resident #2 was a falls risk and had frequent falls. The ADOC reported

that Resident #2 had a alerting device and the bed should be in the lowest position with one bed rail. Interview with Staff #11 and #12 who indicated that Resident #2 was very unsteady, had frequent falls in and outside home, and that any instructions related to use of alerting device and bed height should be located on Kardex which is included in the plan of care. [s. 6. (1) (a)]

2. The licensee failed to ensure that the following are documented: (1) the provision of care set out in the plan of care; (2) the outcomes of the care set out in the plan of care; (3) the effectiveness of the plan of care.

Related to Log#O-000280-13:

Review of clinical records indicated Resident #3 had a therapeutic treatment ordered. Review of health records for a four month period indicated Resident #3 was non-compliant with the therapeutic treatment. Review of the Care Plan during that period indicated to provide the therapeutic treatment as ordered.

Interview with ADOC and Staff #7, 8, 9, 10 who reported was aware that Resident #3 was non-compliant with therapeutic treatment.

Review of Medical Administration Records for a four month period indicated that Resident #3 only received the therapeutic treatment three times in one month; two times in the second month; and none for the third and fourth month. There is no evidence of Resident #3 receiving the therapeutic treatment as per the physicians order as set out in the plan of care. [s. 6. (9)]

3. The licensee failed to ensure that when a resident is reassessed and the plan of care reviewed and revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care related to falls and therapeutic treatment.

Related to Log #O-000280-13:

Review of clinical health records during a four month period Resident #3 sustained ten falls.

Review of the Care Plan during that same period had no evidence related to falls. Review of the Falls Risk Assessment indicated Resident #3 was moderate risk for

falls. Review of Post Falls Assessment documentation indicates five out of nine falls had no evidence of interventions put in place to prevent falls or updates/revisions made to the care plan related to falls.

Interview with ADOC who reported was aware that Resident #3 had frequent falls but Resident #3 would not follow recommendations for ambulation and was non-compliant with falls program and physiotherapy recommendations. ADOC reported Resident #3 needed frequent cuing related to ambulation and therapy aids.

Review of clinical records indicated Resident #3 had a therapeutic treatment ordered. Review of the Care Plan during that same period indicated to administer the therapy as ordered by the physician. Review of health records for a four month period indicated Resident #3 was non-compliant with this therapy.

There was no evidence that the resident's plan of care was reviewed and revised to ensure different approaches and interventions were considered related to fall prevention and therapeutic treatment. [s. 6. (11)]

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 the written plan of care for each resident that sets out planned care to the resident; and that the provision of care set out in the plan of care is documented and the reassessment and trial of interventions related to falls and therapeutic treatment is documented, to be implemented voluntarily.

WN #2: 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 failed to ensure that the policy related to medication management is complied with.

Related to Log #O-000280-13:

Review of clinical records indicated Resident #3 had a therapeutic treatment ordered.

Review of the policy related to therapeutic treatment indicated to follow protocols for applying the treatment as specified in the Vendor policy and procedure manual or in the Nursing text used to support the Resident Care Manual."

Review of the related Nursing Text indicated ""...As with any drug, the therapeutic treatment should be continuously monitored. Routinely check the physician's orders to verify that the client is receiving the prescribed dose. The seven rights of medication administration also pertain.."

Review of the Medication Policy indicated "Follow the standards of practice for medication administration as documented by the College of Nurse of Ontario..."

Review of Medical Administration Records for the administration of the therapeutic treatment for a four month period indicated three staff signatures for one month; two staff signatures for the next month; and no staff signatures for the next two months. During an interview with DOC who indicated staff are to follow College of Nursing of Ontario medication administration standard which includes documentation of medications on MAR.

2. As per O. Reg. 79/10, s. 48(1) "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." As per O. Reg. 79/10, s. 49(1) "The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of resident's drug regimes, the implementation of restorative care approaches and the use of the equipment, supplies, devices and assistive aids. (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."

Review of the Policy entitled "Fall Prevention & Management" VII-G-60.00 dated May 2012 states:
"2. If there is suspicion or evidence of injury the resident should not be moved. The physician should be contacted, and/or arrange for immediate transfer to the hospital, the POA/Substitute Decision Maker will be notified'
4. Initiate a head injury routine (HIR) if a head injury is suspected or if the resident fall is unwitnessed…
5. Monitor HIR for 48 hours post fall for signs of neurological changes…
6. Complete Falls Incident Report under the Risk Management…"

Review of document entitled "Head Injury Routine" states:
"1. Refer to Nursing policy for procedure in head injury routine.
2. Assessment to be completed and recorded: every fifteen minutes – first one hour; every one hour – next three hours; every four hours – next twenty hours."

Related to Log #O-000280-13:

Review of clinical health records indicated that Resident #3 sustained ten falls during a four month period. Review of clinical records indicated in seven out of ten unwitnessed falls the Head Injury Routine assessment was not done or incomplete as per the specified routine. Review of the clinical records for four out of ten falls no evidence of the physician being notified. Review of the clinical records for three out of ten falls no evidence of the POA/Substitute Decision Maker being notified. Review of clinical records found only four out of ten falls had a Falls Incident Report completed. [s. 8. (1) (a),s. 8. (1) (b)]

3. Related to Log # O-000594-13:

Review of clinical records indicated that Resident #2 had eleven unwitnessed falls during a three month period and found that the Head Injury Routine assessment was not done or incomplete as per the specified routine. Review of the same clinical records found no evidence of the physician being notified for two falls.

The licensee failed to document assessments related to Head Injury, notify the physician and POA/SDM and complete a Falls Incident Report as per the licensee's policy. [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 with the licensee policies related to Falls Prevention and Management; Head Injury Routine; and Medication Administration Documentation regarding therapeutic treatment, 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

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):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s.107 (1), whereby the licensee did not ensure that the Director was immediately informed regarding an unexpected or sudden death, including a death resulting from an accident or suicide.

Related to Log #O-000280-13:

As indicated by the resident health care record and Critical Incident Report on a specified date Resident #3 died as a result of an accident. The Director was not informed immediately of an unexpected death. [s. 107. (1)]

2. The licensee failed to comply with O.Reg 79/10, s.107 (3), whereby the licensee did not ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director.

Related to Log #O-000594-13:

As indicated by the resident health care record and Critical Incident Report on two separate specified dates Resident #2 sustained injuries that resulted in transfer to hospital. The Director was not informed within one business day of the injury that resulted in transfer to hospital.

Related to Log #O-000280-13:

As indicated by the resident health care record and Critical Incident Report on a specified date Resident #3 sustained an injury that resulted in transfer to hospital. The Director was not informed within one business day of an injury that resulted in transfer to hospital.

Related to Log # O-000425-13:

As indicated by the resident health care record and Critical Incident Report on a specified date Resident #1 sustained an injury that resulted in transfer to hospital. The Director was not informed within one business day of an injury that resulted in transfer to hospital.

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. These findings relate to incidents that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was applied. [s. 107. (3)]

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 the Director is immediately informed regarding an unexpected or sudden death; and within one business day regarding an injury to resident that results in transfer to hospital and that results in a significant change in the resident's health condition, to be implemented voluntarily.

Issued on this 8th day of August, 2014

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