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
Feb 28, 2014	2014_294555_0001	O-000017-14	Complaint

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 Complaint inspection.

This inspection was conducted on the following date(s): February 6, 7, 10, 13 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered staff, Personal Support Workers (PSW) and Physiotherapy staff.

During the course of the inspection, the inspector(s) interviewed staff, reviewed health records, observed residents, reviewed incident reports and policies "Fall Prevention and Management; Transfer of a Resident to a Hospital; Consent to End of Life Care by Substitute Decision Maker; Authorization of Personal Assistance and Consent to Treatment; and Disclosure Guidelines".

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

Findings of Non-Compliance were found during this inspection.

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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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the written plan of care for resident #1 sets out the planned care for the resident related to falls. [s. 6(1)(a)].

A review of progress notes and incident reports indicates that Resident #1 had several falls which resulted in injuries which required transfer to hospital. Review of Progress notes indicated "Residents floor mattresses removed this shift as they are a falls risk...Resident has received a bed alarm today as a falls prevention measure."

Interview conducted with staff #105 and staff #110 who identified resident # 1 as a falls risk and stated that if someone is prone to falls that fact should be noted in the resident's care plan. Staff #105 stated care plans are found in front of chart and

Kardex binder. Staff #110 also reports if a resident was a fall risk or had multiple falls staff would consider interventions such as: bed/chair alarms in place; foam mattress on floor and lower bed; close supervision; medication and diagnosis review; vss/bp/blood sugar; referral to PT; and if interventions were made staff would then update care plan. There is no evidence on the resident's most recent care plan located in resident #1 chart and Kardex regarding resident #1 being a falls risk. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Review of documentation entitled the Initial Head to Toe Assessment under Foot care Assessment noted that the resident #1 had foot care issues. The documentation entitled Multidiscliplined Care conference indicated family requested resident to have professional foot care and staff was to add the resident's name to list of clients for the private foot care provider affiliated to long term care home to see. Interview conducted with staff #109 who reported that the private foot care provider documents the visits in PCC under "Foot Care Notes" and a hard copy of referral is found in chart under "referrals" tab. No evidence was found in resident's #1 chart in PCC of documentation under "foot care notes" or was a hard copy of the foot care referral found in physical chart, therefore the plan of care was not reflective of the needs and preference of the resident. [s. 6. (2)]

3. The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

Resident #1 had an unwitnessed fall and suffered a injury which did not result in transfer to hospital. Interview with resident #1's POA/SDM who reported was told by staff that resident #1 had a fall "2 weeks ago", but family was not aware. Interview with staff #102 who reported if a fall is witnessed or unwitnessed staff always notify family and transfer if family wishes. There is no evidence that the POA/SDM was contacted regarding this fall.

Resident #1 had a change in status that required medical attention and a change in medication and then had subsequent second change. Family was informed of the both incidents and medication change after the second status change. Family was concerned that they were not made aware of the first episode. Interview conducted

with staff #109 who reported POA is always contacted if resident has change in status. Interview conducted with staff #102 who reported of a resident having a change in status and confirmed no telephone call was made after the first change to notify family. There is no evidence that the POA/SDM was contacted regarding this change in status and treatment. [s. 6. (5)]

4. The licensee failed to 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; (b) the resident's care needs change or care set out in the plan is no longer necessary; or (c) care set out in the plan has not been effective.

Resident's #1 plan of care located on the physical chart and Kardex was dated October 11,2013. Since October 11, 2013 Resident #1 has fallen several times and had a significant change in physiological status which resulted in transfer to hospital. Upon re-admission to the long term care facility a Fall Risk Assessment (return from hospital) was completed indicating the resident was a moderate risk and had multiple falls in last 6 months however there was no change in the resident's care plan. Review of Progress note indicated "Residents floor mattresses removed this shift as they are a falls risk...Resident has received a bed alarm today as a falls prevention measure."

Physiotherapy indicated to staff as per progress note "...Physio has assessed and it was decided that resident #1 is safest to remain walking about. ...Staff are checking on resident #1 every 10 minutes to ensure safety." There is no evidence of Physiotherapy documentation related to the assessment of resident#1 for safety related to falls.

The resident's care plan dated October 11, 2013 remained unchanged despite the falls, assessment and intervention documentation. [s. 6. (10) (b)]

5. The licensee failed to ensure that the care set out in the plan of care is reassessed and the plan of care reviewed and revised at any other time when care set out in the plan has not been effective.

The resident's care plan currently in use dated October 11, 2013 stated that the resident had poor oral hygiene which "requires assistance related to cognitive impairment; ...Mouth care - 1 staff member assist and to provide constant cuing and supervision." Observation records documented by staff for January 2014 indicates that 39 times the resident required total care by staff, and 39 times required two or

more person assist.

The Initial Head to Toe Assessment under Oral Care Assessment indicated Resident #1 had evidence of broken, loose or carious teeth upon admission. Three out of six subsequent Oral Care Assessments indicated that Resident #1 had broken teeth.

Review of the progress notes documented that Resident #1 experienced severe mouth pain. In the progress note staff assessed Resident #1's teeth, and noted "5 teeth on bottom that are broken in places, blackened at the gum line and appear to be rotting. No mouth odour present. No wincing or signs of pain on assessment. ...RN made aware".

The plan of care for Resident #1 was not reviewed and revised when the resident's care was not being effective. [s. 6. (10) (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 the written plan of care for residents sets out the planned care for residents at risk for falls; and is based on an assessment of the resident and the needs and preferences of residents; and involves the resident's substitute decision-maker in the development and implementation of the plan of care; and that the plan of care is reviewed and revised when the resident care needs change, 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is: (a) in compliance with and is implemented in accordance with all applicable requirements under the Act, and (b) complied with.

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 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."

On February 7, 2014 document entitled Speciality Care "Fall Prevention & Management" Policy dated May 2012 was reviewed.

As per said policy under "Procedure: The Registered Staff will... 4. Ensure that preventative interventions are included in the resident's care plan".

Review of progress notes for resident #1 stated "Residents floor mattresses removed this shift as they are a falls risk...Resident has received a bed alarm today as a falls prevention measure." These interventions were not included in the resident's care plan dated October 11, 2013.

As per policy under "Post Falls Assessment: The Registered Staff will...5. Monitor HIR (head injury routine) for 48 hours post fall...".

Review of the document entitled "Head Injury Routine Procedure" indicated instructions state "1: Refer to Nursing Policy for procedure in Head Injury Routine (HIR). 2. Assessment to be completed and recorded: every 15 minutes - first (1) hours; every (1) hour - next three (3) hours; every (4) hours - next (20) hours." The document used to record the Head Injury Routine Assessment does not follow the policy instructions.

Interview conducted with staff #110 who reported that if a resident has a fall that is unwitnessed or witnessed to have hit their head then staff initiate a Head Injury Routine. Interview conducted on with staff #102 who reported that a witnessed or unwitnessed fall receives the same treatment and if staff are suspicious that a resident has had a head injury then they initiate the Head Injury Routine.

For resident #1 review of multiple Head Injury Routine documentation indicated the total number hours being assessed does not follow the policy. The documentation also does not follow the timing of assessments as required by the assessment document.

As per policy under Post Falls Assessment the Registered staff will:..."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 hospital, the POA/Substitute Decision Maker will be notified".

The review of Falls Incident Report and Progress notes indicated no documentation of notification of POA/SDM. Interview conducted with staff #109 who stated POA is always contacted if resident has change in status. Interview with staff #102 who explained procedure that if fall is witnessed or unwitnessed staff always notify family and transfer if family wishes. Interview conducted with resident' #1's POA/SDM who reported that family was told by staff about resident #1 having a fall "two weeks ago" but family was not aware.

The licensee failed to document interventions, monitor Head Injuries and notify the resident's POA/SDM after a fall as per the licensee's policy. [s. 8. (1)]

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 licensee's Fall Prevention and Management Policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions are documented.

During an interview with staff #111 who indicated that physiotherapy staff only document under physiotherapy notes in PCC. Staff #111 reports if resident does not qualify for physiotherapy no further notes are made and no alternatives or interventions are given.

Review of progress note indicated that the resident was "mobilizing independently but is unsteady and remains a fall risk as before...physio referral has been sent..." The Physiotherapy Referral indicated the reason for referral was "ambulation concerns, post fall - with injury, resident has been readmitted from hospital and has been noted to have an increasingly unsteady gait". The referral indicates that the assessment for Physiotherapy services was completed. No additional documentation was found related to Physiotherapy assessment, interventions or recommendations of resident#1 for safety related to falls. [s. 30. (2)]

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 that any actions taken with respect to a resident under a program including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

Issued on this 3rd day of March, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
G. Coles #555