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 sions 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
May 26, 2016	2016_360111_0010	026010-15	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's at Fleming
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

ST JOSEPH'S AT FLEMING
659 Brealey Drive PETERBOROUGH ON K9K 2R8

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

LYNDA BROWN (111)

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): May 12, 13, & 16, 2016

The following inspections were completed concurrently during this inspection: 4 critical incidents related to falls (log # 026010-15, 021663-15, 003657-15 and 008241-15)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care(DOC), RN Manager, Personal Support Workers (PSW), Residents and families.

During the course of the inspection, the inspector also reviewed health care records of four residents, observed four residents, and reviewed the home's Falls Prevention and Management policy.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences related to falls risk.

Re: Critical Incident Log # 003657-15 for resident #004:

Review of the health care record for resident #004 indicated the resident was a high risk for falls. The progress notes indicated the resident sustained a fall on a specified date and time and the resident complained of pain to a specified area. At the time of the fall, the resident was receiving routine analgesic three times a day. The following day, the resident continued to complain of pain to the same specified area. Two days post fall, the resident continued to complain of pain to the specified area and additional injuries were noted to another specified area. The resident was assessed by the Nurse Practitioner (NP) and indicated possible injury to the specified area and "nursing staff to contact physician re: pain management". There was no documented evidence the physician was contacted for pain management. Four days post fall, the resident's Substitute Decision Maker (SDM) expressed concerns to the NP of the residents continued complaint of pain to the specified area and requested a diagnostic test to rule out the injury. The following day (five days post fall) the diagnostic test confirmed injury to the specified area and the physician was contacted. Additional analgesic was ordered at that time.

The resident's care was not provided based on the assessment of the residents needs, as the resident sustained a fall on a specified date and complained of ongoing pain as a result of an injury to the specified area. The resident was not assessed until 2 days post fall by the NP. The NP directed staff to contact the physician for pain management and the physician was not notified until 5 days post fall, when additional analgesic was ordered. The resident did not receive a diagnostic test until four days post fall, at the SDM request, and the diagnostic test confirmed the injury to the specified area [s. 6. (2)].

2. The licensee has failed to ensure that the plan of care was provided to the resident as specified in the plan related to falls risk.

Re: Critical Incident Log# 008241-15 for resident #001:

A critical incident report (CIR) was received on a specified date for a fall resulting in an injury and transfer to hospital that occurred four days before. The CIR indicated resident #001 sustained a fall and was transferred to hospital for assessment and diagnosed with an injury to a specified area.

Review of resident #001 progress notes indicated the resident sustained three falls. Two of the falls occurred in the last four months.

Review of the current care plan for resident #001 related to falls risk indicated the resident was a high risk for falls, unsteady gait, and physical limitations. Interventions included: fall-out mats on floor beside bed when lying down, and falling star logo at room doorway.

Observation of the resident's room indicated there was no falling star logo on the resident's doorway and no fall-out mats noted in the room or on the floor. Therefore, the plan of care was not provided as set out in the plan, related to falls risk. [s. 6. (7)]

3. The licensee has failed to ensure that when the resident was being reassessed, and the plan of care was being revised because the care set out in the plan was not effective, different approaches were considered in the revision, related to falls risk.

Re: Critical Incident Log #003657-15 for resident #004:

Review of the progress notes for resident #004 for the 2015 year indicated the resident was a high risk for falls, sustained 21 falls, and three near miss fall incidents. Five of the

falls resulted in injury to specified areas.

In addition, review of the progress notes for resident #004 during the five month period in 2016, indicated the resident continued to be a high risk for falls, and sustained 7 falls. Three of the falls resulted in injury to specified areas.

Review of the care plan (current) for resident #004 indicated the resident was at high risk for falls.Interventions included:
-Chair exit device in place and functioning when up in wheel chair; falling star logo placed on doorway to alert staff; return to bed after lunch for a rest; staff to assist with transfers; Ultra-low bed, in the lowest position whenever resident is in bed; exit alarm in place and functioning when in bed and tested every shift; Fall out mat on both sides of the bed; Check every hour to ensure safety; Resident to wear proper and non-slip footwear; Reinforce need to call for assistance, ensure call bell is accessible at all times; call bell clipped to gown when in bed; Ensure environment is free of clutter; and have commonly used articles within easy reach.

The Physiotherapist (PT) assessed the resident post falls and provided additional recommendations: the day after first fall with injury, after third fall, after fourth fall with additional injuries, after 11th fall, and after the 14th fall. The PT indicated after 21 falls, "No changes in PT intervention, falls rate are not changing and self-transfers due to behaviours which is beyond scope of PT practice".

The following interventions were requested by the SDM related to falls risk:
-after the 4th fall (and sustaining injury to specified areas on two separate occasions), the SDM requested 2 side rails while in bed and a bed alarm. Two days later, the SDM also requested a trunk restraint. Two fallout mats at the bedside and the bed alarm were implemented. The following day, a trunk restraint was applied to the resident's mobility aide. Four months later, the use of an additional trunk restraint was discussed with SDM and consent was provided three days later for both trunk restraints. A month later, the SDM again requested the second trunk restraint to prevent falls and the restraint was implemented. The following day at the annual care conference, indicated the "Family not pleased" one of the trunk restraints was not in place resulting in the resident sustaining another fall. The following month, staff reported the resident was able to remove both trunk restraints and "continues to be at risk for falling". The following month, the SDM requested one side rail discontinued as the resident was demonstrating responsive behaviours with possible risk for injury. Staff expressed concern over SDM request and would inquire about it. Seven days later, the physician ordered the bed rails discontinued.

Therefore, when the resident continued to fall (and sustain injuries), different approaches were not considered until the SDM requested them and were not implemented at the time of the requests. Some of the different approaches were also not implemented as recommending by PT. The interventions of the trunk restraints and bed rails were noted for a specified period of time to ineffective due to responsive behaviours and other interventions were not considered, where possible. [s. 6. (11) (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 the plan related to falls risk is based on the resident's needs and preferences, is provided to the resident related to falls risk, and when interventions have been ineffective, other interventions are considered where possible, to be implemented voluntarily.

WN #2: 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):
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 ensure the Director was informed no later than one business day after the occurrence of the incident of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital.

Re: critical Incident Log# 008241-15 for resident #001:

A CIR was received on a specified date for a fall resulting in an injury and transfer to hospital that occurred four days before. The CIR indicated the resident #001 sustained a fall and was transferred to hospital and diagnosed with an injury to a specified area.

Review of the progress notes for resident #001 indicated the day after the fall occurred, the home was notified by the hospital that the resident had sustained an injury to a specified area.

Interview with the DOC indicated the Director was notified of the fall which resulted in an injury when the CIR was submitted (4 days later). [s. 107. (3)]

2. Critical Incident Log # 026010-15 for resident #002:

A CIR was submitted to the Director on a specified date for a fall incident that caused an injury and for the which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIR indicated three days before, resident #002 sustained a fall and was transferred to hospital and diagnosed with an injury to a specified area.

Interview of the DOC indicated the Director was notified of the fall with injury when the CIR was submitted (three days later). [s. 107. (3)]

3. Re: Critical Incident Log # 003657-15 for resident #004:

A CIR was submitted to the Director on a specified date for a fall incident that caused an injury and for the which the resident was taken to hospital and resulted in a significant change in the resident's health status. The CIR indicated four days before, resident #004 sustained a fall with injury to specified areas and complained of pain to a specified area. The resident was transferred to hospital for assessment the same day and received treatment for the injuries and was returned to the home the next day. The following day, the resident continued to complain of pain to a specified areas and was transferred back to hospital and diagnosed with an infection and injury to a specified area.

Review of the progress notes for resident #004 indicated on a specified date and time, the resident sustained a fall and complained of pain to specified areas. The resident was sent to hospital for assessment and treatment the same day and returned from hospital the following day. The resident was bedridden upon return from hospital due to complaints of pain to specified areas. Later the same morning, a call was received from the hospital physician indicating the resident's diagnostic testing revealed injury to specified areas. The following day, the resident continued to demonstrate pain to specified areas, and demonstrated signs of infection to a specified area. The resident was transferred back to hospital and diagnosed with an infection to a specified area and additional injuries to a specified area.

Interview of the DOC indicated the Director was notified of the fall with injury that occurred four days later when the CIR was submitted. [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 notified within one day of incidences where residents sustain a fall that causes an injury and for which is taken to hospital and with a significant change in health condition, to be implemented voluntarily.

Issued on this 26th day of May, 2016

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

Original report signed by the inspector.