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

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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
Sep 20, 2013	2013_230134_0008	O-000585-13, O-000599-13	Complaint

Licensee/Titulaire de permis

MARYCREST HOME FOR THE AGED
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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 10, 11, 12 and 13, 2013

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care, Unit Managers (UN), Registered Nurse (RN), Registered Practical Nurses (RPN), several Personal Support Workers and Housekeeping Staff

During the course of the inspection, the inspector(s) toured Woodland Unit, reviewed the identified residents' health records and reviewed the Fall Prevention and Management Program # 8-41.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Falls Prevention

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. (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 comply with the LTCHA 2007, S.O. 2007, c.8 section 6 (11) (b), in that when Resident #3's plan of care was reviewed and revised regarding risks of falls, different approaches were not considered to prevent further falls while alone in his/her room.

On September 11, 2013, staff members #S10 and #S11 were interviewed. They reported that Resident #3 has a tendency to lean backwards when walking. They indicated that the Lazy Boy chair in the resident's room is low and it is difficult for the resident to get out off it by self because it is too low for the resident's height.

Staff members #S10 and #S11 indicated that in order to prevent falls while resident is pacing the hallways, staff is to take the resident to his/her room when tired. Resident is to sit in his/her lazy boy chair or lie on his/her bed. The resident has a history of frequent falls due to poor gait and poor judgement.

According to the resident's substitute decision maker (SDM), Resident #3 has had frequent falls in his/her room. The SDM also reported that on one occasion the housekeeper had washed the floor in the resident's room while the resident was in bed and that when the resident got up the resident slipped on the wet floor. The progress notes between June 21 to September 10, 2013, were reviewed. There were 4 identified unwitnessed falls while Resident #3 was in his/her room alone. These falls were reported to be on specified days in June, July and August, 2013.

During the course of the inspection in September, 2013, Resident #3 had been taken to his/her room at approximately 9:00 after breakfast and the bedroom door had been closed because the resident had been pacing in the hallway. When Inspector #134 looked in on the resident, the resident was lying in poor body alignment on the edge of the mattress, with knees off the bed.

According to staff #S10 and #S11, Resident #3 is usually taken to his/her room and the door is closed to prevent the resident from coming out in the hallway and disturbing other residents.

Resident #3's plan of care was reviewed and there is an indication that the resident is at high risk of falls due to an unsteady gait. The interventions noted in the plan of care are limited to indicate the resident is on the " falling star" program and there are no clear directions on how to prevent the resident from falling while in his/her room.

On September 11 and 13, 2013, Inspector 134 observed the housekeeping staff washing the floor in certain rooms. The floors which had been washed, were observed to be very wet. The housekeepers, who were interviewed, indicated the floors in residents' rooms are usually washed at meal time and while residents are at lunch. On September 12, staff member #S16 reported to the inspector that when he/she got to another resident's room immediately after lunch to toilet the resident, the bedroom floor was very wet, placing both staff and the resident at risk of falls and injury. Staff member #S16 indicated that this happens more frequently when part time housekeeping staff work on the unit.

As such, these evidences show that Resident #3 remains at risk of falls when left alone in his/her room with the door closed. The intervention of taking the resident to his/her room when tired, is not effective in preventing falls. New approaches would need to be considered in the revision of the plan of care as it relates to fall prevention. [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 that when Resident #3's plan of care is reviewed and revised, new approaches are considered to prevent falls while resident is in his/her room by self, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg 79/10 section 51 (2) (b) (c) and (d), in that Resident #3's individualized plan to promote and manage bowel and bladder continence is not implemented; that consistent assistance to manage and maintain continence or receive assistance to become continent some of the time is not provided.

Staff members #S10 and #S11 were interviewed and they indicated Resident #3, who suffers from dementia, will normally give signs to indicate the need to be toileted. These signs and behaviours are well described in the plan of care and both staff members reported that based on their assessment Resident #3's behaviours are more apparent immediately after meals.

Resident #3's plan of care was reviewed. There is an entry under the behaviour management section of the plan that provides clear direction to staff as it relates to taking the resident to the toilet immediately after meals, especially when exhibiting certain behaviours. [s. 51. (2) (b)]

2. On September 10, 2013, Resident #3 was visited by Inspectors #134 and #194 at 15:00 and the was observed to have been incontinent of stool at that time.

The care plan was reviewed and there is an entry under the nursing diagnosis of bowel incontinence that specifies the resident is to be clean, dry and odour free and one of the interventions listed was that the resident was to be toileted after lunch.

On September 12, 2013, Inspector #134 was on the unit at 9:15. Resident #3 was observed resting in own room. The resident had not been toileted and according to staff member #14, the resident had finished breakfast at 9:00. Staff member #16, who was assigned to Resident #3 was interviewed. Staff member #S16 reported Resident #3 was taken to own room after breakfast but was not taken to the toilet. Staff member #S16 indicated he/she had to help the bath nurse transfer another resident in the bathtub and was not able to take Resident #3 to the toilet immediately after breakfast. Staff member #S16 indicated he/she was not able to request assistance from other staff members because one PSW had gone to break at 9:00 and the other had to stay and supervise the dining room while other residents were eating. While Resident #3 was in own room the inspector observed Resident #3 getting up from Lazy Boy chair and proceed to walk out in the hallway. A PSW helped to sit resident down on the sofa in the TV lounge. The resident got up several minutes later and started to pace the

hallway and exhibiting signs of needing to be toileted. Two PSWs #14 and #15 were in the Dining Room but resident was not taken to the washroom when the behavioural triggers were observed. A few minutes later, at approximately 9:40, the resident became incontinent in his briefs. [s. 51. (2) (c)]

3. On September 13, 2013 at 9:15, Resident #3 was sitting on own bed. The resident had finished breakfast before 9:00 and had not been toileted immediately after breakfast. Staff member #S17 assigned to the resident, was asked by the inspector if the resident had been toileted immediately after breakfast. Staff member #S17 replied that he/she had changed the resident's brief prior to breakfast and that today was the resident's bath day and therefore the resident would get toileted later. According to the Unit Manager, Resident #3 had been observed exhibiting signs of needing to go the washroom after breakfast. The Unit Manager reported to the Inspector that staff member #18 had been asked, at approximately 9:00, to toilet the resident. When interviewed by the inspector at 9:20, staff #S18 replied he/she had not gotten to it yet. Several minutes later staff member #17 took Resident #3 to the toilet and the resident did have a bowel movement in the toilet.

The plan of care in Resident #3's bedroom closet was reviewed. There is an entry under the toileting section of the plan that indicates, to toilet the resident in am, at bedtime, after lunch and on both rounds on night. There is another entry under the behaviour section of the plan, specifying that the resident is to be toileted immediately after meals.

Staff member #S14, #S15, #S16, S#17 and #S18 were interviewed and everyone indicated that it is not realistic to toilet Resident #3 immediately after breakfast and lunch due to the high demands placed on them at mealtime and that it is difficult to leave the dining room to toilet Resident #3 immediately after meals. They reported that breaks are at 9:00, 9:15 and 9:30 while residents are still in the dining room and that breakfast is served between 8:15 and 10:00. The RPN was interviewed and indicated that since he/she is responsible to administer medication to 50 residents on the unit, he/she would not be available to supervise the dining room while staff are giving care or toileting residents.

As such Resident #3's individualized plan to promote bowel and bladder continence is not implemented consistently and the resident does not receives the assistance necessary to manage and maintain bowel and bladder continence. [s. 51. (2) (d)]

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 #3's individualized plan to promote bowel and bladder continence is implemented and that the resident receives assistance from staff to manage and maintain bowel and bladder continence, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with the O.Reg 79/10 section 36, in that staff are not using safe transferring techniques when assisting Resident #3.

On September 11, 2013 at approximately 12:00, Inspector #134 observed Resident #3 sitting on the edge of the arm chair in the TV lounge. Two staff members were observed trying to assist the resident out of the chair on two occasions. Staff members #S14 and #S15 were observed using unsafe transferring techniques. The resident was observed with legs extended forward. When staff approached the resident they did not reposition the resident's legs to allow the resident to stand with ease. They did not place the resident's hands on the arms of the chair so the resident could help self to lean forward. Both staff members were observed struggling while pulling the resident by the arms and shoulder to a standing position. [s. 36.]

Issued on this 20th day of September, 2013

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

Colette Assali, LTCH Inspector #134