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
Jun 6, 2014	2014_295556_0018	O-000400-14, O-000371-14	Critical Incident System

Licensee/Titulaire de permis

COUNTY OF RENFREW
9 INTERNATIONAL DRIVE, PEMBROKE, ON, K8A-6W5

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

MIRAMICHI LODGE
725 Pembroke Street West, PEMBROKE, ON, K8A-8S6

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

WENDY PATTERSON (556)

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 23, 26, 27, and June 2, 3, 2014.

Log #O-000418-14 was included in this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Resident Care Coordinators (RCC), Personal Support Workers (PSW), Registered Nurses (RN), and Registered Practical Nurses (RPN).

During the course of the inspection, the inspector(s) observed Resident to Resident interactions, Staff to Resident interactions, observed a meal service, reviewed weekly rounds policy, prevention of resident abuse or neglect policy, restraint policy, staff education material, the responsive behaviour program, the falls prevention program, and the health care records of resident #001, #002, #003, #004, #005, #006, #007, and #008.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed comply with Ontario Regulation 79/10, s. 53. (4) (a) (b) (c) in that the licensee failed to ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, strategies are developed and implemented to respond to these behaviours, and actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented.

A review of the progress notes on Resident #005's health care record indicated that the resident demonstrated the responsive behaviours of verbal and physical aggression toward staff and co-residents.

A weekly round note stated that Resident #005 was having periods of aggression and anger.

A review of the care plan in Resident #005's health care record indicated that Resident #005 demonstrated the responsive behaviours of wandering, and resisting care, however there was no indication of the responsive behaviours of verbal or physical aggression.

In an interview the Resident Care Coordinator stated that when residents are demonstrating increased or new responsive behaviours a Team Huddle Form (red sheet) is filled out resulting in a behavioural care plan. She/he further stated that this should have occurred for Resident #005 however if the red sheet was not in the deceased resident file then it didn't get done. A review was conducted of the file and the red sheet was not located.

A review of Resident #005's plan of care indicated that the responsive behaviours of verbal and physical aggression that were being reported and documented in the progress notes, did not have the behavioural triggers identified, or strategies developed and implemented to respond to the behaviours, nor were actions taken to respond to the needs of Resident #005 related to the new responsive behaviours. [s. 53. (4)]

2. A review of Resident #006's admission history indicates that the resident had a history of the responsive behaviours of wandering, hoarding, rummaging, aggression, and agitation prior to admission to the home.

A review of the progress notes on the Resident’s health care record indicate that the responsive behaviours of wandering, restlessness, agitation, and exit seeking were exhibited on ten separate days over a six week time frame.

An Annual Health Review Note stated that Resident #006 had behaviors of wandering, exit seeking, voiding on floor in room, hoarding, and rummaging.

In an interview PSW #S102 stated that she/he had observed Resident #006 exhibiting the responsive behaviours of wandering, and exit seeking.

A review of the electronic care plan in Point Click Care and the printed care plan in the binder on the care unit indicated that responsive behaviours have not been included in the resident's care plan.

In an interview the Resident Care Coordinator stated that a red sheet should have been completed for Resident #006 resulting in a behavioural care plan.

A review of Resident #006’s plan of care indicated that the responsive behaviours of wandering, restlessness, agitation, and exit seeking that were being reported and documented in the progress notes, did not have the behavioural triggers identified, or strategies developed and implemented to respond to the behaviours, nor were actions taken to respond to the needs of Resident #006 related to the responsive behaviours. [s. 53. (4)]

3. On a specified date an incident occurred whereby Resident #008 became physically and verbally aggressive, and touched a vulnerable another resident in a sexually inappropriate manner.

A review of Resident #008’s admission history in the health care record indicated that there was a history of the responsive behaviours of wandering, hoarding, agitation, verbal abuse, and physical aggression prior to admission to the home.

A review of the progress notes on the Resident’s health care record indicated that responsive behaviours were exhibited on twenty one separate days in a four week time frame.

In an interview Registered Staff #S101 indicated that Resident #008 was unpredictable and at times uncontrollable, and created a safety risk for vulnerable

residents and staff.

A review of the care plan in place at the time of the incident indicated that responsive behaviours were not included in the resident's care plan.

In an interview the Resident Care Coordinator stated that Resident #008 should have had a red sheet filled out resulting in a behavioural care plan.

A review of Resident #008's plan of care indicated that the responsive behaviours that were being reported and documented in the progress notes did not have strategies developed and implemented to respond to Resident #008's responsive behaviours. [s. 53. (4) (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 for every resident demonstrating responsive behaviours, the behavioural triggers are identified, strategies are developed and implemented to respond to the behaviours, and actions are taken to respond to the needs of the resident, including assessments, reassessments, and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed comply with the Long Term Care Homes Act 2007, c. 8, s. 31 (2) 4. in that the licensee failed to ensure that a physician, or registered nurse in the extended class has ordered or approved the restraining of Resident #002.

Resident #002 was observed sitting in a wheel chair with a table top in place as well as a lap belt that was fastened under the table top.

A review of Resident #002's health care record indicates that there is a written care plan indicating that the resident is to have a lap belt and table top restraint in place when up in chair.

Registered staff member #S100 reviewed resident #002's health care record with Inspector #556 and could not locate a physician or registered nurse extended class order for the table top and lap belt restraints being used for Resident #002. Staff member #S100 stated that there is supposed to be a physician's order for every restraint. [s. 31. (2) 4.]

2. The licensee has failed comply with Long Term Care Homes Act 2007, c. 8, s. 31 (2) 5. in that the licensee failed to obtain consent from Resident #001, and #002 or the Substitute Decision Maker for Resident #001, and #002 for restraining by a physical device.

On a specified date Inspector #556 observed Resident #001 sitting in the resident lounge in a broda chair with a table top in place that was fastened at the back of the

chair. Resident #002 was observed sitting in a wheel chair with a table top in place as well as a lap belt that was fastened under the table top.

A review of Resident #001 and #002 most recent fall risk assessments indicated that both Residents were determined to be at a high risk for falls.

A review of the written care plan for Resident #001 indicated that a table top or a seat belt restraint was to be used when up in chair. Resident #002's written care plan indicated that both a table top and a lap belt restraint were to be used when up in chair.

A review of the homes policy entitled Resident Safety - Restraints: SOP # N-960 with a revision date of May 13, 2013 states that prior to application of the restraint, informed consent must be obtained from the substitute decision maker.

Registered staff member #S100 reviewed resident #001 and #002's health care record with Inspector #556 and could not locate a signed consent on either resident's health care record. Staff member #S100 stated that there is supposed to be a signed consent for every restraint. [s. 31. (2) 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed comply with Ontario Regulation 79/10, s. 110 (2) 4. in that the licensee failed to ensure that when Resident #001 was restrained by a physical device the resident was released from the physical device and repositioned at least once every two hours.

On a specified date and time Inspector #556 observed Resident #001 to be sitting in the resident lounge in a broda chair with a table top in place that was fastened at the back of the chair. During the two hours and twenty two minutes that Resident #001 was observed by Inspector #556 she/he was not released from the physical device and repositioned.

In an interview the Resident Care Coordinator stated that Resident #001 is not able to adequately reposition him/herself while in a broda chair with a table top in place, therefore the expectations is that the PSW staff would remove the table top and readjust the Resident's position every two hours at a minimum. [s. 110. (2) 4.]

Issued on this 20th day of June, 2014

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