Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 11, 2020	2020_805638_0006	023120-19, 023125-19, 001683-20	Critical Incident System

Licensee/Titulaire de permis

Board of Management for the District of Nipissing West
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

Au Chateau
100 Michaud Street STURGEON FALLS ON P2B 2Z4

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

RYAN GOODMURPHY (638)

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): January 29 - 31 and February 3 - 5, 2020.

The following intakes were completed in this critical incident system inspection:
-One log was related to an incident with an injury which resulted in the resident being sent to hospital;
-One log was related to an incident of resident to resident physical abuse; and
-One log was related to an adverse drug reaction which resulted in the resident being sent to hospital.

A complaint inspection #2020_805638_0005 was conducted concurrently with this critical incident system inspection.

Please note: Shelley Murphy (Inspector #684) was also on-site throughout the course of the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist, Physiotherapy Assistant, a physician, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
1 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	Légende 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 to ensure that for each resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including assessment, reassessment and interventions and that the resident's responses to interventions were documented.

A critical incident system (CIS) report was submitted to the Director related to an incident involving an adverse reaction to resident #002.

Inspector #638 reviewed resident #002's health care records and identified in their progress notes that since their return from hospital, the resident had a change in their behaviour. The progress notes identified multiple notations on three consecutive dates, where the resident refused a specific therapeutic intervention.

The Inspector reviewed resident #002's plan of care and noted that the resident's plan did not identify the new behaviours or any interventions to address the resident's newly identified behaviour. The Inspector reviewed the resident's health care records and was unable to identify any resident assessments related to the change in their behaviours.

Inspector #638 reviewed resident #002's annual and quarterly Minimum Data Set (MDS) assessments since the time of their admission and identified that the resident was not identified as having the specific behavioural indicators.

In an interview with Inspector #638, PSW #102 indicated that if a resident's behaviour had changed, they would report to registered staff and that the BSO team would become involved to determine strategies.

During an interview with Inspector #638, RPN #118 indicated that if a resident had a change, that information would be relayed to registered staff so the resident could be assessed. The RPN indicated that increased monitoring of the resident should occur if there was concern regarding their safety.

In an interview with Inspector #638, RN #111 indicated that resident #002 had a change in their behaviours upon returning from the hospital. The RN acknowledged manifestations of the behaviour.

The home’s policy titled “Responsive Behaviour Management And Abuse/Neglect Prevention Program” last revised April 5, 2019, indicated that the home was to develop strategies for prevention which may include; awareness, skills and knowledge related to responsive behaviours for staff; developing interventions to minimize triggers or respond effectively for specific residents and to prevent the escalation of potentially harmful or abusive situations.

In an interview with Inspector #638, the DOC indicated that the resident’s status was changed and that staff were aware to monitor and ensure the resident’s safety after the incident. Upon reviewing the resident’s plan of care, the DOC acknowledged that although the staff had ensured care was being done, the resident’s plan did not identify their new behaviour. [s. 53. (4) (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 any newly identified responsive behaviours have actions taken to respond to the needs of the residents, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

A CIS was submitted to the Director related to an incident of resident to resident abuse, which resulted in resident #004 requiring a specific intervention.

Inspector #638 reviewed resident #004's care plan and identified a specific intervention was to be implemented at specific times.

The Inspector observed resident #004 on three dates. During each observation it was identified that the resident did not have the specific intervention implemented at the specified times.

The Inspector reviewed resident #004's progress notes and identified a notation from physician #112 which indicated they had left an order to discontinue the specific intervention.

Inspector #638 interviewed the Physiotherapist and PTA #108 and identified that resident #004 had the specific intervention due to a change in their status but the resident was back to their previous level of functioning and no longer used the specific intervention.

In interview with Inspector #638, PSW #102 indicated that direct care staff referred to the resident's electronic care plan for resident specific information and care direction. The

PSW indicated that they would report to registered staff if there was a concern with the plan of care.

During interview with Inspector #638, RPN #110 indicated that they referred to the resident's electronic care plan for specific information. The RPN indicated that if a care intervention was no longer current, they would report to the assigned care plan worker who would review and update the plan.

The home's policy titled "Resident Care Plan – C-010" last reviewed June 2018, indicated that the care plan must be revised and dated as such with any changes affecting care.

In an interview with Inspector #638, the DOC indicated that registered staff updated the resident specific plan of care. They indicated if an intervention was finished, registered staff were supposed to go in and update the plan. The Inspector reviewed resident #004's care plan with the DOC who indicated that the intervention for their specific intervention should have been removed when it was discontinued. [s. 6. (10) (b)]

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. (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):
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 has failed to ensure that the Director was informed no later than one business day after the occurrence of a medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

A CIS report was submitted to the Director on a specific date related to an adverse drug reaction where resident #002 was taken to hospital.

Inspector #638 reviewed the CIS report and identified that three days prior, resident #002 was found to have had an adverse reaction. The Inspector noted an after hours number attached to the CIS report which identified that RN #111 had called in the incident after business hours on the first business day after the incident. The CIS report was submitted one day later, on the second business day, after the incident.

During an interview with Inspector #638, the DOC indicated that the DOC and Administrator were the only one's who had access to the reporting portal and that on the due date of the report, they were not on site and had attempted to report from home. The DOC indicated they had difficulty doing so and therefore directed registered staff to report the incident after hours via the after-hours line. [s. 107. (3) 5.]

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.