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
Mar 23, 2016	2016_289550_0011	026843-15	Complaint

Licensee/Titulaire de permis

THE GLEBE CENTRE INCORPORATED
950 BANK STREET OTTAWA ON K1S 5G6

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

GLEBE CENTRE
950 BANK STREET OTTAWA ON K1S 5G6

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

JOANNE HENRIE (550)

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 23, 25, 26 and 29, 2016.

This complaint inspection is related to resident care services.

During the course of the inspection, the inspector(s) spoke with The Director of Care (DOC), registered staff members (RN and RPN), personal support workers (PSW) and a family member.

In addition, the inspector reviewed resident health care records and procedures related to falls.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **3 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. (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 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.

During an interview, a family member and substitute decision maker (SDM) for resident #001 indicated to Inspector #550 that he/she was not informed when there was a change in resident #001's condition. He/she indicated resident #001 fell several times, his/her physical condition deteriorated and he/she had to request that the resident be sent to the hospital. He/she had to call the physician and request that the physician called the home to inquire about resident #001's condition as he/she was deteriorating and the family member and SDM was very concerned. Resident #001 died at the hospital a few days later of a specific injury.

Inspector #550 reviewed resident #001's health care records and noted that resident #001 was admitted to the home in 2013. As per the documentation in resident #001's actual plan of care and discussion with the resident's family member and SDM, the resident was mostly independent with all activities of daily living requiring minimum supervision or encouragement. Resident #001 was independent with a walker for mobility and had some communication difficulties expressing himself/herself although he/she was able to speak on the telephone and be understood by others.

The documentation also revealed the following:

On a specific date in August 2015 in the morning, the resident had an unwitnessed fall in his/her room and sustained an abrasion to two specific body parts. Again that same day during the evening the resident had an unwitnessed fall in his/her room with no apparent injury.

On a specific date in August 2015 in the morning, the resident had an unwitnessed fall in his/her room with no apparent injury. That same day during the evening resident #001 was found to be very suspicious and confused by staff and a urine sample was collected to rule out an infection.

On a specific date in August 2015, the RPN called the physician to have a medication ordered for agitation and restlessness. At that time the physician ordered a specific medication to be administered twice daily by mouth when needed for agitation and restlessness.

On a specific date in August 2015 in the morning, a PSW observed the resident sliding out of the bed and assisted him/her to the floor with a pillow. No injury was noted.

On a specific date in August 2015, a referral for a physiotherapy assessment was sent due to increased falls and decline in mobility.

On a specific date in August 2015, the resident was agitated and pacing in the morning and returned to bed after breakfast. The resident slept until lunchtime and he/she was then brought to the dining room in a wheelchair due to weakness where he/she only drank a glass of juice. The resident remained agitated and indicated he/she was not feeling well. The resident was given a specific medication by mouth for a temperature. Just before suppertime, the staff reported the resident was teary and mumbling; they could not understand what he/she was saying and he/she was unable to hold his/her cup. At suppertime, the resident was unable to hold his/her utensils and had to be fed. At bedtime snack, resident #001 was unable to hold a cookie in his/her hands or his/her cup therefore had to be fed. During bedtime care, staff had to transfer the resident with the mechanical lift because he/she was not cooperative.

On a specific date in August 2015 in the morning, the physician visited the resident after receiving a call from the resident's family member and SDM the previous evening. He suspected a specific type of infection and ordered an antibiotic, some blood work and a

chest x-ray. He called resident #001's family member and SDM to informed him/her of his findings. When the family member and SDM visited resident #001 at lunchtime, he/she requested the resident be transferred to the hospital and the resident was sent to the hospital shortly after.

Two days later, resident #001 died in hospital.

There was no documentation in the health care records to indicate that the resident's family members or SDM had been informed at any time of the resident's falls and deteriorating condition except when the family member and SDM called himself and questioned the nurse on a specific date in August 2015.

During an interview, RPN #100 indicated to the inspector that when a resident sustains a fall or there is a change in his/her condition, the staff will notify the substitute decision maker and document in the progress notes or on the incident report ie: post fall assessment in PCC. She indicated she did not notify resident #001's family member and SDM of the changes in the resident's condition or falls because he/she calls often to inquire about resident #001's health and she was going to inform him/her upon his/her next call. She further indicated recognizing that she should have called and informed him/her of the changes and falls and she should have documented this in the progress notes.

The Director of Care indicated to the inspector the staff should have informed resident #001's family member and SDM of the changes in his/her condition and falls.

As evidenced above, resident #001's substitute decision maker was not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

2. The licensee has 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 the resident's care needs change or care set out in the plan is no longer necessary

A review of resident #001's health records revealed that the resident fell 4 times between four (4) specific dates in August 2015. It was documented in the progress notes that on the morning of a specific day in August 2015, resident #001 was found on the floor in his/her room. Later that evening, he/she was found on the floor next to the bed. On the morning of a specific day in August 2015, he/she was found lying on the floor beside the

bed. In the early morning of a specific day in August 2015, a PSW observed the resident sitting on the edge of his/her bed, sliding to the floor. The PSW assisted the resident to the floor with a pillow.

Inspector #550 reviewed the plan of care for resident #001 and observed it was documented that the resident was at low risk for falls and he/she was independent with a specific mobility aid. As such, resident #001's care plan was not re-assessed when his/her care needs changed after he/she sustained 4 falls. [s. 6. (10) (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 the residents' plan of care are revised when a resident's care need changes, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's plan of care is based on an interdisciplinary assessment of safety risks.

A review of resident #001's health care records revealed that the resident had a specific disease which required an anticoagulant therapy. The medication administration record for this resident indicated the resident was taking a specific anticoagulant medication once daily by mouth at supper for the prevention of blood clots.

Inspector #550 reviewed the written plan of care for resident #001 and observed there was no documentation to indicate that the resident was taking a special medication to prevent blood clots and that this could be a safety risk for hemorrhaging.

As such, the plan of care for resident #001 is not based on an interdisciplinary assessment of safety risks. [s. 26. (3) 19.]

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 residents taking anticoagulant medication have their plan of care revised to include the safety risk, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (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. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, has the resident been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

A review of resident #001's health records revealed that the resident fell 4 times between four (4) specific dates in August 2015. It was documented in the progress notes that on the morning of a specific day in August 2015, resident #001 was found on the floor in his/her room. Later that evening, he/she was found on the floor next to the bed. On the morning of a specific day in August 2015, he/she was found lying on the floor beside the bed. In the early morning of a specific day in August 2015, a PSW observed the resident sitting on the edge of his/her bed, sliding to the floor. The PSW assisted the resident to the floor with a pillow.

RPN #100 indicated to the inspector that when a resident has fallen, registered staff have to do a 72 hour post fall documentation in the progress notes and the home does not have a clinically appropriate assessment instrument that is specifically designed for falls.

During an interview, the Coordinator of Nursing Program indicated to Inspector #550 that prior to September 2015, staff were expected to do a post fall assessment using the Appendix 3, "Post fall assessment and documentation check list", and answers to questions in Appendix 3 are to be documented in the progress notes in PCC, therefore. Because resident #001's falls occurred before September 2015, Appendix 3 should have been used by registered staff to do a post fall assessment and documented in the resident's progress notes.

Inspector #550 reviewed the documentation in the resident 001's progress notes and was unable to determine that a post fall assessment had been conducted after each of resident #001's falls in August, 2015. [s. 49. (2)]

Issued on this 23rd day of March, 2016

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

Original report signed by the inspector.