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
Jul 24, 2014	2014_365194_0007	000382-13,001237-13	Critical Incident System

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF DURHAM
605 Rossland Road East, WHITBY, ON, L1N-6A3

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

HILLSDALE ESTATES
590 Oshawa Blvd. North, OSHAWA, ON, L1G-5T9

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

CHANTAL LAFRENIERE (194), MATTHEW STICCA (553)

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): July 9, 10, 11, 14, 15,16,17 & 18, 2014

During the course of this inspection the following Critical Incident Inspections were completed; Logs #000352-14,#000119-14,#001237-13, #000382-13,#001216-13,#000474-14,#000496-13,#000120-14,#000877-13,#000519-14 and #000665-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT), Occupational therapist adjuvent, Social Worker (SW),Physio Therapist (PT), Behavioural Support Ontario staff (BSO), Residents and Family members.

During the course of the inspection, the inspector(s) reviewed identified resident's clinical health records, observed resident/staff interaction and provision of care, transferring of residents by staff, reviewed the licensee's internal investigations related to identified incidents, licensee's policies related to prevention of falls, restraints, lifts and transfers, code yellow/missing resident and prevention of abuse, review of the home's minutes related to fall team meeting and staff educational records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Medication
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 failed to comply with LTCHA, 2007 s.6(1)(c) when the resident's plan of care does not set out clear direction to staff and other who provide direct care to the resident.

LOG#: O-000474-14

On an identified date Resident #32 was transferred by two staff members using 2 staff side by side transfer without the use of the recommended transfer equipment. Resident #32 was later diagnosed with an injury.

Plan of care for the resident #32 in effect at the time of the incident directs; Extensive assistance 2 staff to provide extensive assistance for all transfers

OT assessment directs; 2 staff side by side transfer with use of specific transfer equipment, but advised staff that they can always go up with transfer/use a mechanical lift if resident can't stand.

Interview with PSW #134 and RPN #130 confirm resident #32 was being transferred using a mechanical lift on the day shift for two months prior to the incident. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007 s.6(10)(b) when residents were not reassessed and the plans of care reviewed and revised when the residents care needs changed.

On an identified date, Resident #30 was observed by inspector #553 and RN #137. RN #137 asked Resident #30 to unfasten the velcro belt alarm, resident was unable to comply. RN #137 confirmed that Resident #30 could become agitated and pull belt apart at times. RN #137 confirmed that at this time the resident's device is a restraint, since the resident cannot unfasten it.

The OT stated that when the velcro belt was applied to resident #30 the resident was able to unfasten the device. OT has stated that her understanding was that nursing staff were responsible for reassessing the resident's capacity for the use of the device on a daily basis.

PSW staff interviewed on the unit where Resident #30 resides stated that they assess the velcro belts daily, but only to ensure that the alarm is functioning, not to assess the capacity of the resident's ability to use the device.

On an identified date Resident #24 was up in the wheelchair with a push button seat belt applied. Resident #24 was unable to undo the applied seat belt when asked by Inspector #553.

The following day, the OT stated that Resident #24 was reassessed by OT and Staff #108. Resident #24 was unable to undo the applied push button seat belt, which had not been identified as a restraint.

The ability to unfasten the applied belts for Resident # 24 & #30 had changed, no re-assessments had been provided and the plans of care had not been reviewed or revised. [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 ensuring that the written plan of care;
-provides clear direction to staff and others who provide direct care to the resident related to transfers
-are reviewed and revised when care needs change related to the application of velcro belt alarms and seat belts., 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 failed to comply with LTCHA 2007, s.31(2)4 when a physician's order was not obtained for the physical restraint in use

On an identified date, Resident #30 was observed by inspector #553 and RN #137. RN #137 asked Resident #30 to unfasten the velcro belt alarm, resident was unable to comply. RN #137 confirmed that Resident #30 could become agitated and pull belt apart at times. RN #137 confirmed that at this time the Resident's device is a restraint, since the resident cannot unfasten it.

Clinical health record for Resident #30 was reviewed and there is no order for physical restraint.

On an identified date, Resident #24 was up in the wheelchair with a push button seat belt applied. Resident #24 was unable to undo the applied seat belt when asked by Inspector #553.

Clinical health record for Resident #24 was reviewed and there is no order for physical restraint.

Interview with DOC confirms that the home practice is to obtain an order for the use of any physical restraint. [s. 31. (2) 4.]

2. The licensee failed to comply with LTCHA 2007, s.31(2)5 when consent was not obtained for the physical restraints in use

The Clinical health records for Resident #24 and #30 were reviewed. There is no evidence that a consent had been obtained for the physical restraint.

Interview with DOC confirms that the home practice is to obtain written consent for the use of any physical restraint. [s. 31. (2) 5.]

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 ensuring that the restraining of a resident by a physical device may be included in a resident's plan of care only if there is a physician's order and consent obtained., 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 O.Reg. 79/10 s.36 when PSW did not use safe transferring and positioning devices or techniques when assisting residents.

LOG:O-001216-13

On as identified date, a staff reported a co-worker had transferred two residents unassisted, contraindicated by the resident's plans of care.

Resident #30's plan of care directs at the time of the incident;
Transferring:
Extensive assistance- 2 person(s)to provide extensive assistance from bed to wheelchair
Toileting: Total dependence 2 person to provide total assistance

Resident #31's plan of care directs at the time of the incident;
Transferring and Toileting: total dependence 2 staff to use mechanical floor lift with full small sling to transfer resident from bed to commode for toileting and back to bed.

The identified staff had been provided the required education related to lift and transfers.

An internal investigation completed by the home confirmed that the identified staff had transferred two residents unassisted, not following the directions of the care plans. [s. 36.]

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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #4: 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).

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):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Log #O-000665-13 CI #M539-000051-13

The licensee failed to inform the Director no later than one business day after the occurrence where Resident #24 was missing for less than three hours and returned to the home with no injuries or adverse change in conditions on an identified date.

Review of progress notes for Resident #24 was completed;

On an identified date Resident #24 was noted to be exit seeking at start of shift and requiring redirection to room and unit frequently. After an extended search Resident #24 was found outside the home, assessed and returned to the unit with no injury.

DOC indicated that a Critical Incident Report had not be submitted to the Director for the incident.[s. 107.(3)1.]

2. Regarding Log # O-000119-14 CI# M539-000005-14.

On an identified date, Resident #36 had a fall. Resident #36 did not report any pain at the time of the incident, throughout the day Resident #36's pain increased Resident #36 was sent to hospital for assessment and returned to the home. Later in the day Resident #36 sustained a second fall, expressing pain and discomfort and was immediately sent to hospital. The following day, the hospital confirmed an injury.

DOC indicated that a Critical Incident Report had not be submitted within the required time lines to the Director for the incident. [s. 107. (3) 4.]

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 ensuring that the Director is informed of the incidents in the home no later than one business day after the occurrence of the incident;
-a resident who is missing for less than three hours and who returns the home with no injury or adverse change in condition.
-an injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 20(1) when RN received allegations of verbal abuse of a resident by staff and did not report the incident to the management as per licensee's policy.

Log: O-000877-13

Licensee's policy " Abuse & Neglect - Prevention, Reporting & Investigation" ADM-01-03-05 directs
REPORTING/INVESTIGATION PROCEDURES
-All staff, volunteers, contractors and affiliated personnel must immediately report any alleged, suspected or witnessed incidents of abuse or neglect to the appropriate supervisor on duty. Together with the person who witnessed the alleged/suspected/witnessed abuse or neglect, the home must immediately report to the Ministry of Health and Long Term Care.

On an identified date, staff to resident verbal abuse was reported to RN #124.

RCC #126 became aware of the reported allegations fourteen days later and immediately commenced the abuse investigation, and notified the Director.

The DOC states that no report related to the allegations of verbal abuse was brought forward by the RN. Abuse training for RN #124 had been provided in 2013. [s. 20. (1)]

Issued on this 25th day of July, 2014

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