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 prévue 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 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
Nov 8, 2018	2018_730593_0015	004214-18	Complaint

Licensee/Titulaire de permis

City of Ottawa
Community and Social Services, Long Term Care Branch 200 Island Lodge Road
OTTAWA ON K1N 5M2

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

Peter D. Clark Centre
9 Meridian Place OTTAWA ON K2G 6P8

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

GILLIAN CHAMBERLIN (593)

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): October 1 - October 5, 2018.

Inspector #573 completed a concurrent Critical Incident (CIS) inspection (#2018_593573_0015) during this complaint inspection. The following non - compliance was identified by Inspector #573 and is captured in this report:

s. 8 (1) (b)- related to CIS logs #006497-18 and #017961-18

The following intakes were completed during this inspection:

One complaint intake: log #013378-18 related to resident care concerns and two Critical Incident (CIS) intakes: log #006497-18 and #017961-18 related to falls resulting in a change in condition.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Program Manager of Personal Care (PMOPC), Program Manager of Resident Care (PMORC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

During the course of the inspection, the Inspector(s) reviewed Critical Incident (CIS) reports, resident health care records and licensee relevant policies and procedures. In addition, the Inspector(s) observed the provision of care and services to residents, the residents environment and observed staff to resident interactions.

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.
2 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	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 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) was given the opportunity to participate fully in the development and implementation of resident #003's plan of care.

A complaint to the Director was received, by the SDM for resident #003 related to a fall sustained by the resident, resulting in a hospital admission for 16 days as a result of a significant injury. The complainant stated that they were not notified about resident #003 falling, until approximately 6 - 7 hours after the fall occurred.

During an interview with Inspector #593, October 4, 2018, the SDM for resident #003 indicated that the fall happened on a weekend afternoon, approximately 1500 hours. The SDM further added that they did not receive notification from the home about the fall until 2130 hours that night. When resident #003 was discharged from the hospital, the SDM was told that the medication orders were sent to the home’s physician for approval however at approximately 1500 hours, resident #003 was displaying specific symptoms as they had yet to receive their specific medications to manage these symptoms. The SDM mentioned it to one of the PSWs who explained that they were not doing this (referring to the residents regular medications) anymore, the Physician approved it and now the resident is on the home’s palliative care regimen and are only giving the resident the medications that are on the palliative regimen list. The SDM indicated that they were not aware of the medication changes until the PSW told them and resident #003 had already missed a dose of their regular medications.

A review of resident #003 progress note’s found the following:

Day 1- At 1515 hours during the shift report, a co-resident came and informed staff that

resident #003 was found on the floor. Immediate Treatment: Writer, RPN, day RN and evening PSWs went to the resident. Resident #003 was lying on the carpet floor in the lounge area.

Day 18- Returned from the hospital at 1100 hours.

Day 18, 1730 hours- Writer phoned resident #003’s SDM and spoke about their concerns and assured them that the specific medications had been ordered for resident #003. The SDM was also was informed of the subsequent change of end of life care orders.

A review of the residents health care record found the following:

• General Incident Report dated the day of the fall- at 1515 hours during the shift report, a co-resident came and informed staff that resident #003 was found on the floor. Writer, RPN, day RN and evening PSW’s went to the resident. Resident #003 was lying on the carpet floor in the lounge area. It was documented in this report that the SDM was notified at 2100 hours, the same day of the fall.

• Physicians Order dated day of return from hospital, 1420 hours- Phone order, d/c all previous medications and there was an order for two specific medications.

• Reference guide for managing end of life care symptoms- faxed to the home’s physician the day the resident returned from the hospital with a list of standard orders for the homes palliative care protocol.

During an interview with Inspector #593, on October 5, 2018, RPN #115 indicated that they contacted resident #003’s SDM after the fall however they could not remember the time that the SDM was contacted. The RPN added that usually they would call the SDM 1 -2 hours after the incident. RPN #115 indicated that the SDM for resident #003 wished to be informed of anything related to resident #003.

During an interview with Inspector #593, on October 4, 2018, RN #110 indicated that when a resident returned to the home palliative, the home have their own palliative orders that are implemented and usually other medications are discontinued unless the doctor or the SDM say otherwise. The RN added that this protocol for palliative care was usually discussed with the SDM however they cannot remember doing this the day the resident returned from the hospital, with the SDM of resident #003.

During an interview with Inspector #593, on October 5, 2018, the PMORC indicated that they were not sure why there was a delay in calling the SDM after resident #003 sustained a fall, and the home's expectation is that the SDM is called immediately after an incident. The PMORC further indicated that the home has a palliative care process where all medications are discontinued with some exceptions, and they start end of life medications as part of a standing order. The PMORC was not sure whether this was explained to the SDM of resident #003, when the resident returned from the hospital (log #004214-18). [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in resident #003's plan of care was provided to the resident, as specified in the plan.

A review of resident #003's documented plan of care, by Inspector #593, found the following documented entry:

Nursing Diagnosis: Risk of injury from Falls
Related to: At risk for falls due to history of falls, physical and cognitive impairment.
Interventions: Assess falls for a pattern to determine possible causative factor. Complete fall assessment (RAFT) and do huddle immediately after fall to establish what could have been done to prevent this and further fall.

Resident #003 sustained a fall resulting in a significant injury. Two days later, resident #003 was sent to the hospital as a result of the fall and subsequent injury.

Inspector #593 reviewed resident #003's health care records and documentation related to the fall. There was a general incident report completed however the post falls assessment (RAFT) or post fall huddle were not completed post fall.

During an interview with Inspector #593, on October 4, 2018, RPN #115 indicated that they were working the evening shift the day of resident #003's fall. RPN #115 indicated that a post falls assessment was supposed to be completed, however they did not complete a post falls assessment after resident #003's fall resulting in a significant injury.

During an interview with Inspector #593, October 5, 2018, the PMOPC indicated that a RAFT was to be completed for residents after their third fall or if the resident required hospitalization. An incident report is to be completed for all falls and this should reflect if a huddle has been completed post fall. The PMOPC further added that a post falls assessment was not completed for resident #003 after the fall resulting in a significant

injury, as it was the residents first fall (log #004214-18). [s. 6. (7)]

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 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 and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's policy "Falls Prevention and Management" was complied with.

According to O.Reg 79/10, s. 48 (1) 2, every licensee of a long-term care home shall ensure that the following interdisciplinary programs is developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

On October 04, 2018, upon Inspector #573 request the Administrator provided the

home’s updated fall prevention policy and program. A review of the home’s Falls Prevention Program, March 2014, including the Falls Prevention Program: Resident Assessment for Falls Tool (RAFT), AP & OP No: 315.08, September 2013, items 2 and 3, under section Operational Procedure, indicated that the registered staff will:
Item 2: Host a post fall meeting (Huddle) and complete the Huddle form on the shift when the fall occurred.

Item 3: Complete the RAFT when the condition or circumstances of the resident require: upon admission, where there is an injury from falling requiring hospitalization and if the resident has more than two (2) falls in a one (1) week (7 days) period.
A review of post fall huddle form #315.08B included multiple questions related to resident / environmental factors. The post fall huddle form indicated that it was designed to assist in determining why the resident fall. A review of Home’s RAFT identifies the residents fall risk level as moderate, high and very high based on the total scores.

Related to Log: #006497-18, for resident #002

Critical Incident Report (CIR) #M609-000016-18, indicated that an incident that caused an injury to resident #002 for which the resident was taken to hospital and that resulted in a significant change in the resident’s health status.

On October 05, 2018, Inspector reviewed resident #002’s health care records. Resident #002 was admitted in the home with multiple diagnoses including history of falls. In a review of resident #002’s progress notes over a 10 week period, it was documented that the resident had five falls. A post-fall huddle form was not found for the resident’s fall incidents. Further, two falls were noted within a three day period and two falls were noted on the same day, the Resident Assessment for Falls Tool (RAFT) to reassess resident fal risk level was not found in resident health record.

Related to Log: #017961-18, for resident #004

Critical Incident Report (CIR) #M609-000038-18, indicated that an incident that caused an injury to resident #004 for which the resident was taken to hospital and that resulted in a significant change in the resident’s health status.

On October 05, 2018, Inspector reviewed resident #004’s health care records. Resident #004 was admitted in the home with multiple diagnoses including history of falls. In a review of resident #004’s progress notes, it was documented that the resident fell on

twice during the same month. A post-fall huddle form was not found for the resident's fall incidents. Further, the Resident Assessment for Falls Tool (RAFT) to reassess resident fall risk level following two falls within a three day period was not found in resident health record.

On October 05, 2018, Inspector #573 spoke with the acting Program Manager of Personal Care (PMOPC), who indicated that if a resident had more than two (2) falls in a one (1) week period registered nursing staff were expected to complete an RAFT tool to identify the resident's fall risk level, which helps in the implementation of fall prevention interventions. Further, the PMOPC stated that post fall huddle form was supposed to be conducted in the (page 3 and 4) of the fall incident report. Inspector #573 reviewed the post fall huddle form 315.08B and the fall incident report in the presence of acting PMOPC. It was observed that all the questions in the post fall huddle form to assist in determining the resident fall was not included in the fall incident report.

On October 10, 2018, the acting Program Manager of Personal Care, stated to Inspector #573 that they were unable to find the documented Resident Assessment for Falls Tool (RAFT) showing reassessment of fall risks for resident #002 and resident #004, as per the home's policy (log #006497-18 and #017961-18). [s. 8. (1) (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

Issued on this 5th day of December, 2018

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

Original report signed by the inspector.