Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 19, 20, 21, 25, 28, Nov 22, 29, Dec 1, 2011; Jan 6, 2012	2011_055154_0004	Critical Incident

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH CENTRE OF SUDBURY
1140 South Bay Road, SUDBURY, ON, P3E-0B6

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

ST.GABRIEL'S VILLA OF SUDBURY
4690 Municipal Road 15, , Chelmsford, ON, P0M-1L0

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

GAIL PEPLINSKIE (154)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Site Manager, VP Clinical Services, Director of Care (DOC), Registered staff (RN/RPN), Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk throughout 2 resident care areas and various common areas, observed interactions between residents and staff, reviewed electronic and written plans of care, reviewed the health care records of 3 residents, reviewed the home's policy related to Falls Prevention and Management issued September 13, 2010 and last revised September 15, 2011.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. A resident's plan of care does not provide clear directions to staff and others who provide direct care. Inspector interviewed a PSW, who was providing care to a resident on October 21, 2011. PSW told the inspector the following about the resident's care:
-the resident returned from hospital with an infectious condition and there is an isolation sign currently posted on their door
-a yellow band is used across their doorway to keep other residents from wandering into their room
-resident has an alarm on wheelchair and in bed and 2 sides up at the head of their bed when in bed
-resident uses a hi-low bed in the lowest position and must keep it flat, "resident likes it flat"
-resident needs assistance and guidance for toileting, "1 staff to keep reminding resident to stand tall otherwise will lean forward" and can weight bear but needs 1 staff constantly with resident for toileting
-resident has a raised toilet seat now which makes toileting much easier
-resident does not walk, is in a wheelchair when up
On October 21, 2011, the inspector confirmed the above through observation of the resident, who was in the hi-low bed in the lowest position with the alarm on the bed. A sign was posted on their door identifying "Contact Precautions" and a yellow band was hanging on the left side of the door. A raised toilet seat was in place on the toilet of their ensuite bathroom, however, the plan of care did not include the above interventions for the resident.[LTCHA 2007 S.O.2007,c.8,s.6(1)(c)]
2. A resident's plan of care does not provide clear directions to staff and others who provide direct care.
Inspector reviewed the plan of care for a resident on October 20, 2011. The resident fractured their hip in September, 2011 and according to the progress notes has some complaints of pain. The plan does not identify this problem or how to manage the pain.
A PSW, told inspector October 20, 2011 that the resident is transferred using the sit to stand lift and is also toileted with this lift. PSW stated that this is based on the Occupational Therapist's direction. The plan does not identify the use of the lift for transfers.
PSW told the inspector that staff use a bed and chair alarm for resident and they clip it to their lower back so they do not remove it. Inspector observed that the alarm was clipped to resident's lower back when in bed October 20, 2011, however, the plan of care does not identify this intervention.
PSW told inspector that resident's bed is positioned in the lowest position. Inspector observed the bed in lowest position October 20, 2011 while resident was in bed sleeping in the afternoon. Plan of care does not include this intervention.
PSW told inspector that resident is toileted on rising in the morning and before and after meals. During shift report on October 20, 2011 at 3 pm the RPN told the staff that resident was to be toileted regularly because they thought that resident was falling when trying to go to the bathroom. This intervention is not identified on their plan of care.[LTCHA 2007 S.O.2007,c.8,s.6(1)(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 two specific residents and all residents' plans of care set out clear directions to staff and others who provide direct care to residents, 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 subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A resident had a fall in September 2011 and fractured their hip. Since the fracture the resident's health care record identifies that the resident had 4 subsequent falls in October, 2011.
Documentation in the resident's progress notes indicates that on a particular day in October, 2011 "the resident tried to get out of bed and out of their chair a total of 8 times between 1900 and 2100". On another day in October,2011 the resident "tried to get out of bed 6 times since the beginning of the night shift, the resident was helped back to bed each time, resident takes off their tab mobility monitor (bed alarm)". The resident's plan of care does not identify their risk for falls. [O.Reg 79/10 s.26.(3)10]

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 plan of care for a specific resident and all residents is based on,at a minimum, interdisciplinary assessment with respect to the risk of falls, 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 subsections:

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. Inspector reviewed policy "Falls and Falls Prevention" issued September 12, 2010 and revised September 15, 2011. It identifies to use "Incident Assessment Log" found in progress notes under "type" in Point Click Care(PCC). Policy identifies that "all registered staff will complete the proper documentation on the 'Incident Assessment Log' for each fall a resident experiences". Policy also identifies that "staff is to complete each section, at the bottom of the 'Incident Assessment Log' please select edit care plan box, this will bring up the resident's care plan for any revision that may be required".
2. Inspector asked RN, to check a resident's health care record for the completed post-fall assessment subsequent to their fall and fracture in August, 2011. The RN was not able to find a completed post-fall assessment.
This post-fall assessment instrument was not completed after a resident's fall with fractures, in August, 2011.
3. Inspector interviewed the Director of Care(DOC) regarding the "Falls and Falls Prevention" Policy. The policy identifies that "registered staff will complete the proper documentation on the 'Incident Assessment Log' found in the Resident's Progress Notes in PCC for each fall a resident experiences". DOC told the inspector that they were not sure if this is the post-fall assessment instrument the home is to use or not.
Inspector asked an RPN about the post-fall assessment instrument, RPN did not know what it was and was unable to find it on PCC.
Inspector interviewed RN, Education Coordinator, RN was not able to find a completed post-fall assessment for a resident subsequent to their fall and fracture in September, 2011. RN stated "this is a good tool but is not used".
Inspector 154 reviewed the health care record for the resident and was not able to find a completed post-fall assessment.

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 when a resident has fallen, the resident is assessed using a post-fall assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 20th day of January, 2012

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