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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
Jul 30, 31, Aug 1, 10, 13, 15, 16, 17, 2012	2012_140158_0007	Critical Incident

Licensee/Titulaire de permis

BLIND RIVER DISTRICT HEALTH CENTRE
525 Causley Street, P.O. Box 970, BLIND RIVER, ON, P0R-1B0

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

BLIND RIVER DISTRICT HEALTH CENTRE - LTC UNIT
525 CAUSLEY STREET, P. O. BOX 970, BLIND RIVER, ON, P0R-1B0

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

KELLY-JEAN SCHIENBEIN (158)

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 Administrator, the Chief Nursing Officer, the Manager of the LTC unit, the RAI Coordinator, Registered Nursing Staff, Personal Support Workers, Residents and Families.

During the course of the inspection, the inspector(s) conducted a walk through of resident care areas, observed staff to resident interactions, observed resident care delivery, reviewed health care records and reviewed various policies and procedures.
The following log and Critical Incident Report were reviewed as part of this Critical Incident Inspection: S-000735-12, S-000736-12, CI # 2865-000005-12, CI # 2865-000006-12.

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

Ontario

Ministry of Health and Long-Term Care	Ministére de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**

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).

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 Inspector reviewed the health care record including the plan of care for resident # 02 on July 31/12. An entry in the progress notes by staff # 102 indicated that the resident was not wearing a 'lap belt' when the resident was in the wheel chair (w/c). The resident's plan of care did stipulate to apply the seat belt restraint when the resident is in the w/c. The care set out in the plan of care was not provided to resident # 02 as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s. 6.(7)]
2. The inspector observed on July 30/12 at 1630hr that staff # 105 used the chorus lift to transfer resident # 08 from the chair into the resident's w/c. The resident's plan of care identified that 2 staff are required when transferring the resident. The care set out in the plan of care was not provided to resident #08 as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s. 6.(7)]
3. The Inspector reviewed the health care record including the plan of care for resident # 01 on July 30/12. The Inspector noted that the plan of care identified that the resident is at risk when smoking. The intervention "ensure resident wears smoking apron when smoking" was found in the the plan of care under smoking safety. The Inspector observed that staff # 102 unlocked the courtyard door so that resident # 01 could go out to courtyard to smoke on July 30/12 at 1745hr and on July 31/12 at 1230hr. The Inspector observed that the resident did not wear a smoking apron or was provided or offered one by the staff. The care set out in the plan of care related to smoking safety was not provided to resident # 01 as specified in the plan of care. [LTCHA 2007, S.O. 2007, c.8, s. 6.(7)]
4. The Inspector reviewed the health care record including the plan of care for resident # 01 on July 30/12. The Inspector noted that the plan of care identified that the resident was at risk to fall with several fall prevention strategies. Resident # 01 room was observed by the Inspector on July 30/12 to be cluttered with a large computer stand, O2 machine, a large comfy chair and various wires and tubing spread on the floor which blocked the egress to the bathroom. The plan of care does not reflect a fall preventive strategy to ensure that the room is clutter-free. The home did not ensure that there is a written plan of care that sets out, clear directions to staff and others who provide direct care to resident # 01.
[LTCHA 2007, S.O. 2007, c.8, s. 6.(1)(c)]
5. The Inspector reviewed the health care record including the plan of care for resident # 01. The June 23/12 assessment of resident # 01 identified the following; requires assistance of 1 staff for am and pm care but is able to toilet herself during the day; uses a wheel chair (w/c) for long distances such as to the dining room but will use her cane for ambulation with her sling on at other times. It was also identified in the assessment that the resident will wander in hs hours as she is hungry or thirsty and that staff are to remind her to ask for help.
The written plan of care dated June 20/12 is not reflective of the June 23/12 assessment of the resident needs and subsequently, the direction related to the staff's assistance with dressing and toileting, as well as, the resident's current mobility device is contradictory. Also there was no direction found related to strategies to manage the resident's wandering at night.
The written plan of care for resident # 01 does not set out clear directions to staff and others who provide direct care to resident 01. [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 ensuring 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. CI # 2865-000006-12 submitted to the Ministry, identified that resident # 01 was found on the floor and was transferred to hospital where it was determined the resident sustained a fracture. The Inspector reviewed the health care record of resident # 01 on July 30/12 and noted that the RN from Emergency was called by the RPN on the LTC unit to come to assess the resident as the resident was having increasing pain post fall. The RN schedule was reviewed on July 31/12. On July 31/12, the Inspector spoke with the Chief Nursing Officer who verified that the RN scheduled to work night shift in the Emergency Department is identified as the "charge Nurse" who is responsible for the whole building including the Long Term Care unit.
The Administrative policy "Charge Nurse" was reviewed and identifies that the Charge RN "provides clinical assessment and care to residents of LTC when the need of the resident falls out of the scope of practice of the Registered Practical Nurse."
In discussion on July 31/12, the Administrator stated to the Inspector that the LTC beds are housed within the "Corporation" of the hospital which includes the LTC unit. Legislation related to exceptions to the 24 hr RN requirement was reviewed with the Administrator. It was identified that there are 32- LTC beds which fall under the 24 hr RN requirement and do not meet the requirements of the exemption of staffing of the 24-hr Registered Nurse.
The home did not ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

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. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

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 Inspector reviewed the health care record including the plan of care for resident # 02 on July 30/12. Staff # 107 documented in the progress notes that resident # 02 fell out of her chair. The Emergency Acute Care RN came to assess the resident when staff # 107 called the emergency department to report that the resident was grimacing in pain. The Emergency Charge Nurse received an order from the physician for treatment of the resident's injury and send the resident for x-ray in am. Assessment of the physical status of resident # 02 was documented however a post fall assessment using a clinically appropriate assessment instrument, that is specifically designed for falls, was not found. The home failed to ensure that when a resident has fallen, 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)]
2. The home's policy "Falls Prevention and Management Program Protocol" was reviewed by the Inspector on July 30/12. Although the policy identifies generic strategies to manage falls, it fails to include a review of the resident's drug regime or the implementation of restorative care approaches. The home failed to ensure that its falls prevention and management program provided strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. [O.Reg 79/10, s. 49 (1)]

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 subsections:

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.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
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 home did not ensure that the Director was informed within one business day after the occurrence of incident in the home, whereby a resident was taken to hospital as a result of injury.
CI # 2865-000005-12 identified that resident #02 fell and sustained an injury resulting in a transfer to hospital. The Director was not informed no later than one business day post incident. [O.Reg 79/10, s. 107.(3)4]
2. CI # 2865-000006-12 identified that resident # 01 was found on the floor and was transferred to hospital where it was determined the resident sustained a fracture. The Director was not informed no later than one business day post incident.[O.Reg 79/10, s. 107.(3)4]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The Inspector reviewed the health care record including the plan of care for resident # 02 on July 30/12. A seat belt was applied to the wheel chair belonging to resident # 2 as the resident had previously fallen out of the w/c. An order for a Protective Assistive Safety Device (PASD) was obtained from the physician. The POA consented to the use of the (PASD). Resident # 02 progress notes identified that staff # 102 observed that the seat belt ("lap belt") was not engaged. Staff #102 observed that the resident was unable to undo the seat belt when it was clipped. A record of application for the "lap belt" use in June/12 was found. Omission of the resident's response was noted.
The resident was hospitalized and returned to the home. The Inspector noted that the resident's seat belt was engaged on July 30 and 31/12. The Inspector also observed that the resident was not able to undo the seat belt.
An order for a PSAD was found in the physician's order section. Resident # 02 progress notes were reviewed and consent for either a PASD or a restraint post hospitalization was not found. Documentation related to the alternatives considered was also not found.
The home did not ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and that the following was documented: what alternatives were considered and why those alternatives were inappropriate, The person who made the order, what device was ordered, and any instructions relating to the order,consent and all assessment, reassessment and monitoring, including the resident's response. [O.Reg 79/10, s. 110.(2),(4),(6)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. During the Inspector's walk about in the home on July 30/12, the Inspector observed that eye drops , analgesia ointment and the prescribed cream ordered for resident # 2 were on the resident's bedside table. An order for prescribed cream was found in the resident's health care record however there was no order that the cream could be left at the bedside.
The home did not ensure that drugs were stored in a secure and locked area. [O.Reg 79/10, s. 129.(1)(a)(i)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. On July 31/12, the Inspector observed that staff # 106 who is not a member of the Registered staff was allowed entry into the medication room, in which drugs are stored, by staff # 102 and left alone so that a review of the nursing/medical supplies which are located in the medication room could be done. Staff # 106 identified to the Inspector that the ordering of nursing/medical supplies is part of a new assignment. The home failed to ensure that access to the drug supply was restricted to persons who may dispense, prescribe or administer drugs in the home. [O.Reg 79/10, s. 130.2.ii]

Issued on this 17th day of August, 2012

[redacted]

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