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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 20, 21, 22, 25, 27, 28, 29, Jul 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 26, 30, 31, Aug 1, 2, 3, 2012	2012_048175_0011	Critical Incident

Licensee/Titulaire de permis

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND
983 Burnham Street, COBOURG, ON, K9A-5J6

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

GOLDEN PLOUGH LODGE
983 BURNHAM STREET, COBOURG, ON, K9A-5J6

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

BRENDA THOMPSON (175)

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 Identified Physician, Senior Management staff including the Administrator, Director of Care, Associate Director of Care, Two Registered Nurses(RN),2 Registered Practical Nurses (RPN), four Personal Support Workers, Environmental Services Manager, Administrative and Policy Co-ordinator, three residents on resident #1 and #2 home area.

During the course of the inspection, the inspector(s) reviewed resident #1 and resident #2 clinical health records specific to Critical Incident issues, Resident Home Area Evening Routines, Maintenance Log, Room Change Sheet Res #1, and Elder Care Manual on resident #1,2, home areas, Policies and Procedures-Critical Incidents, Prevention, Reporting and Elimination of Elder Abuse, Falls Management, Post-Fall Management, observed resident #1 room and resident #2 rooms and an identified resident home area.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

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).

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).

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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Review of Health Care Record including Care Plan for resident #1 indicates resident #1 had a high risk for falls due to multiple factors. There were no clear directions to staff regarding nurse call device or the use of side rails/assist rails.

2.Interview with senior staff member confirmed the written need for side rails or any safety device should be documented in the resident care plan.

3.Interviews with two staff, indicated that for resident #1 the call bell pad and side rails/half rails, were always in use.

4.Interview with another staff member indicated resident #1 had identified communication deficits.It was further reported that the staff member could not remember giving resident #1 the call bell the day of the Critical Incident resulting in resident death.

5.Interview with a registered nursing staff member indicated side rails/half rails were always in use for resident #1.

6.Interview with senior staff members indicated that the staff did not have resident #1 call bell pinned or clipped to the resident.

The licensee failed to ensure that there was a written plan of care for resident #1 that set out clear directions to staff and others who provide direct care to the resident for the use of a call bell and the use of 2 assist rails.[Ref. s.6(1)(c)].

2. 1.Care Plan review for resident #1 identifies the resident was at high risk for injury/falls and indicates that the resident had a bed alarm in place on the bed.Interventions included that staff will ensure the bed alarm is functioning properly.

2.Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed that the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning. On the day of the Critical Incident resulting in resident death, there was no bed alarm device provided to resident #1.

3.Interview with a senior staff member, confirmed that about 6 months ago a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them.

4.The personal alarm care intervention was not effective in alerting staff of the resident's increased movement prior to experiencing a fall.The resident's needs related to high fall risk were not re-assessed and the care plan was not reviewed and revised when the resident's personal alarm was not effective.

5.Resident #1's care plan indicates the resident's continence issue is identified as the primary risk trigger for falls.Nursing progress notes reviewed, indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions prior to the Critical Incident. Registered nursing staff neglected to manage the resident's continence needs to reduce the risk of falls.

6.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had fallen within the time frame being assessed. The resident's care plan was reviewed but not revised when the interventions to manage the resident's continence needs were ineffective.

7.Nursing progress notes were reviewed and indicated the resident fell from bed four times prior to the Critical Incident. The bedrails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. There was repeatedly no documentation or report of any re -assessment of resident #1's safety needs related to the ongoing use of half rails.

8.Interview with identified Physician confirmed that the side rails/half rails were implicated in the Critical Incident resulting

in the death of resident #1.

9.Physio Quarterly re-assessment was reviewed and indicates the resident risk of falls was "not applicable" and not assessed.Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced falls from the bed, documented on the nursing progress notes.
A second Physio Assessment, indicates incorrectly that resident#1 fell 1-2 times in a six month period. Review of resident Progress notes indicate resident#1 fell from bed four times in six months.

10.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls.

The licensee failed to ensure that resident #1 was re-assessed and the plan of care reviewed and revised when the care set out in the plan of care was ineffective.[Ref. s.6(10(c)].

3. 1.Resident #1 risk for falls is characterized by multiple risk factors.Staff Interventions include the use of bed alarm when the resident is in bed.Ensure that it is working properly.Put bed in it's lowest position.Provide specific bedtime routine, provide continence care because it is a trigger for risk for falls.Keep resident's bed in the lowest position.Resident #1 is identified with a communication deficit related to a medical condition.

2.Interview with a senior staff member confirmed that staff directions for the use of personal alarms for residents is not documented anywhere in the home.

3.Interview with a second senior staff member confirmed that the care set out in the plan of care for resident #1 to address the high risk for falls was not provided to the resident as specified in the plan on the day of the Critical Incident resulting in resident death.

4.Resident #1's health record including progress notes by registered nursing staff was reviewed and indicated the care set out in the plan of care for resident #1 identified at high risk for falls, and with identified communication deficit, was not provided to resident #1 as specified in the plan on four incidents prior to the Critical Incident.

5.Interview with identified Physician regarding the Critical Incident resulting in the death resident #1 confirmed the fall was a primary implication in the death.

6.Care Plan review for resident #2 eight days following the Critical Incident of resident #1, specified that resident #2 is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

7.Interview with Registered nursing staff member indicated that the staff member was not aware of the personal alarm currently being used for resident #2, but knew it was supposed to be there because the person remembered the plan of care specifies resident #2 is to have a personal alarm.

8.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off - they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Reportedly, Resident #2 has not had a bed alarm for more than 3 months. Resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care reportedly for more than 3 months.

The licensee failed to ensure that the care set out in the plan of care for resident #1 and resident #2 was provided to the residents as specified in their plans, specifically related to both resident's high risk for falls.[Ref. s. 6(7)].

Additional Required Actions:

CO # - 001, 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Critical Incident Report submitted to Ministry of Health and Long Term Care was reviewed and indicated:
The home identified a Critical Incident under O. Reg. 79/10, 2007 s. 107(1)(2) related to the Unexpected Death of resident #1.

2.Interview with a senior staff member indicated that the status of the investigation is complete.It was confirmed that resident#1 health care record was not reviewed/summarized, as part of the post incident analysis.
Interview with a second senior staff member indicated that the home does not have a policy or procedure which outlines the investigation process for any Critical Incident.

3.Interview with a senior staff member indicated staff interviews about resident #1 care confirmed the following findings:
Staff neglected to meet the identified safety needs of resident #1 related to bed height, nurse call access, safety devices including personal bed alarm and half/assist rails.
Staff neglected to manage the resident's safety needs and continence needs, a known trigger to risk for falls. Registered nursing staff neglected to monitor resident#1 to ensure effective use of safety devices related to identified falls risks, including continence care.

4.An amended Critical Incident Report was submitted to the Ministry of Health and Long Term Care and reviewed. There was no information reported to the Director regarding the neglect of resident #1 by the licensee and staff of the home, or immediate investigation of same.

The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (ii) neglect of a resident by the licensee or staff and the licensee failed to report to the Director the results of every investigation undertaken under clause (1)(a), and every action taken under clause (1)(b).[Ref.s. 23(1)(a)(ii) (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following subsections:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. Policies and Procedures related to a Falls Management Program for residents, were reported by a staff member to be under revision for the last three months and were observed not to be available to direct care staff on a specific resident home area.

2.Falls Management Policy was reviewed and does not include home specific, interdisciplinary procedures for Falls Prevention. Staff are referred to the Physio Policy and Procedure Manual.

3.Post-Falls Management Policy was reviewed and does not include home specific interdisciplinary procedures to follow to prevent further falls, when a resident identified at high risk for falls/injury, experiences repeated incidents of falling without injury or hospitalization.

4.Interview with a senior staff member indicated the written need for side rails or any safety device should be documented on the care plan. It was further reported that there are no policies and procedures developed in the home related to the use of resident personal bed or chair alarms used as a safety device to prevent falls or guidelines for staff to follow if the alarms are malfunctioning.

5.Care Plan for resident #1 at high risk for falls, with multiple risk factors was reviewed and indicated two half/assist rails and a nurse call bell, both safety devices, were not identified on the resident's care plan as a falls prevention intervention although they were reported to be in use.

6.Resident #1's health record including progress notes by RPNs was reviewed and indicated that resident #1 fell from the bed to the floor, four times prior to the Critical Incident.

7.Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes.

8. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four times in six months.

9.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had a fall during the review period. The resident's care plan indicated that the resident's continence status triggered the resident climbing out of bed. Resident #1's care plan was reviewed but not revised to include the resident's deteriorating continence status and potential implication for risk of falls.

10.Interview with an identified physician, confirmed resident#1's fall from bed was implicated in a Critical Incident resulting in death.

The licensee neglected to ensure an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury for resident #1 was developed and implemented in the home[Ref. Reg 79/10,s.48(1)1].

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

The following occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well-being of resident #1 related to the identified Critical Incident resulting in death:

1.Resident #1 risk for falls was identified by the home as being characterized by multiple risk factors.Interventions on the resident's care plan included that staff will ensure the bed alarm is functioning properly.Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning as it did not sound to alert staff resident was climbing out of bed.There was no documentation or staff report of any action taken by staff to communicate the malfunctioning alarm in the Maintenance Book, or ensure that the resident had a functioning safety device related to falls prevention. On the day of the Critical Incident, there was no bed alarm device provided to resident #1,in the resident's room.

2.Interview with a senior staff member confirmed that prior to the Critical Incident of resident #1, a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them.The senior staff member reported that 1 staff member only was re-directed to the location of the re-set button.The senior staff member further reported that use of resident Personal Alarms in the home is not documented anywhere. The process is verbal, not written. There are no policies and procedures for the use of resident personal bed or chair alarms used as a safety device for falls prevention. Staff who unplugged/removed resident personal alarms neglected to priorize resident safety needs and jeopardized the health and safety of resident #1 and other residents identified to require personal alarms. Senior staff members neglected to communicate the need for all staff to receive education and training related to the correct/safe use of resident personal alarms as a safety device for residents, neglected to ensure that a policy and procedure for the use of personal alarms as a safety device for residents was developed and communicated to staff, neglected to ensure there was a system in place to monitor and maintain resident personal alarms as a safety device for resident #1.

3.Resident # 1's care plan indicates that resident#1's primary trigger for high risk for falls was related to continence issues. Staff interventions related to risk for falls include staff are to provide specific care. Resident#1 is also identified with a specific communication deficit related to a known medical condition. Interventions include staff are to provide daily routine to meet activities of daily living. The day of the Critical Incident, interviews with staff confirmed that resident #1 resident who had specific known communication deficit, was left, in bed, with the bed at an unsafe height, and without call bell access or a personal bed alarm to call staff for help or alert staff to the movement of the resident in bed.

4.Nursing progress notes indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions. The day of the Critical Incident, staff neglected to manage the resident's known continence needs related to risk for falls. Registered nursing staff neglected to monitor resident#1 to ensure that effective continence care was provided to resident #1.

5.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls.

6.The Falls Management Program currently in the home, directs all staff to follow the Policies and Procedures in the Physio Manual. Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four

times in six months. Physio staff neglected to correctly assess resident #1's risk for falls, to monitor the incidence of falls for resident #1 and to initiate a falls prevention program for resident #1 that could be shared with all other disciplines in the home, so resident #1's risk of falls could be managed/reduced.

7.Review of resident #1's health record indicated the bed rails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. Registered Nursing staff neglected to follow the home's Policy and Procedure Bed and Assist Rails for resident #1 which directs staff to complete a needs assessment for the use of assist rails and staff engaging the side rails will ensure the resident's call bell is accessible to resident. Registered staff neglected to develop a plan of care for the use of assist rails, which includes the reason for their use, for resident #1. There were no specific directions regarding a call bell for resident #1. Specific directions were not provided for staff related to the use of side rails/assist rails.Registered nursing staff neglected to re-assess the use of assist rails for resident #1 after each of the four falls prior to the Critical Incident resulting in death.

8.Registered nursing staff repeatedly neglected to re-assess the falls risk of resident #1 according to RAI assessment done for a specific time frame. No re-assessment observed related to resident #1's falls risk despite the fact that nursing Progress Notes for that time period indicated resident #1 had a fall.Review of RAP MDS Quarterly Assessment on a specific date indicated "No falls since the last identified quarter, which was incorrect, as resident#1 had experienced two falls in the identified time period. An RN documented a monitoring note for resident #1 medications and some health conditions, however,there was no re-assessment observed for resident #1's falls risk, indicating the resident's falls risk was not being monitored by nursing staff.

9.Interview with an identified Physician confirmed resident#1's fall from bed was implicated in the Critical Incident resulting in death.

The following occurrences demonstrate a pattern of inaction by the home that jeopardized the health, safety and well-being of other residents in the home post Critical Incident.

10.Interviews with a senior staff member confirmed that there is no facility specific, interdisciplinary process in place to guide the management of Critical Incidents involving residents.

11.Interview with a second senior staff member confirmed there was no review/investigation of resident #1's health care record, post fall, resulting in a Critical Incident and death, as part of the follow-up analysis to identify immediate corrective actions to prevent recurrence and protect other residents living in the home from potential harm/risk of harm.

12.Two senior staff members confirmed that the staff did not have the call bell pad pinned or clipped to resident#1 on the day of the Critical Incident.

13.Eight days post Critical Incident, a Memo to staff re ensuring all residents call bell access was sent to staff in all resident home areas.

14.Post Critical Incident interview with a senior staff member, confirmed that resident#1 did not have a personal alarm on the day of the Critical Incident resulting in resident death. The senior staff member reportedly did not know why the resident did not have a personal alarm. Immediate action was not taken to ensure the provision of resident personal alarms, reported to be a safety device in use in the home for residents identified at high risk for falls.

15.Care Plan review eight days post Critical Incident, for resident #2 specified that this resident is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

16.Interview with a registered staff member indicated that the staff member was not aware of the personal alarm currently being used for resident #2, but knew it was supposed to be there.The registered staff member neglected to ensure resident #2 had a personal alarm in place to alert staff and manage the resident's high risk for falls.

17.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off - they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Resident #2 was confirmed by staff not to be provided with a bed alarm for more than 3 months. Registered nursing staff on all shifts, including senior nursing staff, repeatedly neglected the identified safety need of Resident #2 for more than 3 months, when staff knew resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care.The senior staff neglected to take immediate action to ensure that all residents identified at high risk for falls in the home, had a functioning personal alarm if the care plan of the resident(s) indicated it was an assessed safety need.Immediate corrective actions were not implemented to ensure that identified deficiencies regarding resident personal alarms were fully addressed.

18.Interview with an identified physician confirmed a plastic bag/garbage can insert was implicated in the Critical Incident resulting in resident death.

19.Senior staff confirmed that a decision was made, not to discontinue the use of the same plastic bag insert in resident garbage cans based on this one situation in all the years that the home had used that particular plastic bag insert would be overreacting.The decision was reportedly based on hygiene and infection control issues, not based on potential risk of harm to residents.

20.Interview with senior staff member confirmed that there are two cognitively impaired, ambulatory residents currently in the home, specifically identified at risk for injury (Resident #3 and Resident #4) due to a related medical diagnosis. Observation of an identified Resident Home Area confirmed garbage cans with plastic bag inserts were observed to be accessible to several confused, ambulatory, wandering residents, including residents #3 and 4, in all resident bathrooms.Senior Management staff neglected to take immediate action to limit access to any and all residents in the home with the potential risk for harm related to the known circumstances of the Critical Incident resulting in resident death.

The licensee of the long term care home failed to ensure that residents are not neglected by the licensee or staff [Ref.LTCHA,2007,c.8,s. 19(1)].

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: 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 subsections:

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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Under Reg 79/10 s. 30 (1) 1. There must be a written description of the falls prevention and management program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized sources when required.

2.Review of the home's Policy for Bed and Assist Rails indicates:
Upon completion of an assessment which indicates that when both assist rails are applied for the safety of the resident, the Registered Staff shall develop a plan of care for the use of the rails, which includes the reason for their use.
...The Staff member raising the rails is to ensure that the rails are properly secured and that the call bell is placed within easy reach of the resident when side rails are in use.

3.Critical Incident Report was reviewed and indicated two assist/half rails rails were in use for resident #1.

4.Interview with a senior staff member confirmed the staff neglected to make sure the resident's nurse call bell pad was pinned or clipped to the resident when staff left the resident in the room the day of the Critical Incident.Interview with a second senior staff member confirmed resident#1's call bell clip was missing the date of the Critical Incident.

5.A review of resident #1's health record indicates there is no written assessment to identify the resident's need for 2 half assist rails placed on the lower half of the resident's bed and staff did not develop a plan of care, which included the reason for their use.

6.Review of Resident #1 nursing progress notes indicated staff did not comply with the home's Policy for Bed and Assist Rails on an identified date when a staff member entered resident #1's room and found that resident #1 fell/climbed out of bed. Both side rails were not in place as per note on bedroom wall. Outside rail not in place to help secure resident from climbing out of bed.

The licensee failed to ensure the home's Policy for Bed and Assist Rails was complied with.[Ref.r.8.(1)].

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 the home's Policy for Bed and Assist Rails is complied with., to be implemented voluntarily.

Issued on this 21st day of August, 2012

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

B Thompson

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BRENDA THOMPSON (175)
Inspection No. / No de l'inspection :	2012_048175_0011
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jun 20, 21, 22, 25, 27, 28, 29, Jul 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 26, 30, 31, Aug 1, 2, 3, 2012
Licensee / Titulaire de permis :	THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND 983 Burnham Street, COBOURG, ON, K9A-5J6
LTC Home / Foyer de SLD :	GOLDEN PLOUGH LODGE 983 BURNHAM STREET, COBOURG, ON, K9A-5J6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CLARE BRIGGS (ACTING)

To THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

the licensee shall develop, and implement a process to monitor that the care set out in the plan of care for all residents is provided to the residents as specified in the plan.

Grounds / Motifs :

1. 3. 1.Resident #1 risk for falls is characterized by multiple risk factors.Staff Interventions include the use of bed alarm when the resident is in bed.Ensure that it is working properly.Put bed in it's lowest position.Provide specific bedtime routine, provide continence care because it is a trigger for risk for falls.Keep resident's bed in the lowest position.Resident #1 is identified with a communication deficit related to a medical condition.

2.Interview with a senior staff member confirmed that staff directions for the use of personal alarms for residents is not documented anywhere in the home.

3.Interview with a second senior staff member confirmed that the care set out in the plan of care for resident #1 to address the high risk for falls was not provided to the resident as specified in the plan on the day of the Critical Incident resulting in resident death.

4.Resident #1's health record including progress notes by registered nursing staff was reviewed and indicated the care set out in the plan of care for resident #1 identified at high risk for falls, and with identified communication deficit, was not provided to resident #1 as specified in the plan on four incidents prior to the Critical Incident.

5.Interview with identified Physician regarding the Critical Incident resulting in the death resident #1 confirmed the fall was a primary implication in the death.

6.Care Plan review for resident #2 eight days following the Critical Incident of resident #1, specified that resident #2 is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

7.Interview with Registered nursing staff member indicated that the staff member was not aware of the personal alarm currently being used for resident #2, but knew it was supposed to be there because the person remembered the plan of care specifies resident #2 is to have a personal alarm.

8.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off- they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Reportedly, Resident #2 has not had a bed alarm for more than 3 months. Resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care reportedly for more than 3 months. (175)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Order / Ordre :

to ensure that the licensee reports to the Director the results of every investigation including neglect of a resident by the licensee or staff and every action taken in in response to every such incident

Grounds / Motifs :

1. 1. Critical Incident Report submitted to Ministry of Health and Long Term Care was reviewed and indicated: The home identified a Critical Incident under O. Reg. 79/10, 2007 s. 107(1)(2) related to the Unexpected Death of resident #1.

2.Interview with a senior staff member indicated that the status of the investigation is complete.It was confirmed that resident#1 health care record was not reviewed/summarized, as part of the post incident analysis.
Interview with a second senior staff member indicated that the home does not have a policy or procedure which outlines the investigation process for any Critical Incident.

3.Interview with a senior staff member indicated staff interviews about resident #1 care confirmed the following findings: Staff neglected to meet the identified safety needs of resident #1 related to bed height, nurse call access, safety devices including personal bed alarm and half/assist rails.
Staff neglected to manage the resident's safety needs and continence needs, a known trigger to risk for falls.
Registered nursing staff neglected to monitor resident#1 to ensure effective use of safety devices related to identified falls risks, including continence care.

4.An amended Critical Incident Report was submitted to the Ministry of Health and Long Term Care and reviewed. There was no information reported to the Director regarding the neglect of resident #1 by the licensee and staff of the home, or immediate investigation of same. (175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Order / Ordre :

the licensee shall 1)develop and implement a home specific, interdisciplinary falls prevention and management program that includes best practices and or prevailing practices, to reduce the incidence and the risk of injury to all residents; 2)ensure that Falls Prevention and Management Program and Training Information is easily accessible to all staff on the resident home areas; 3)that there is a contingency plan developed and implemented to ensure that staff have complete and current information available at all times on each resident home area, during the revision or updating of a Program.

Grounds / Motifs :

1. 1. Policies and Procedures related to a Falls Management Program for residents, were reported by a staff member to be under revision for the last three months and were observed not to be available to direct care staff on a specific resident home area.

2.Falls Management Policy was reviewed and does not include home specific, interdisciplinary procedures for Falls Prevention. Staff are referred to the Physio Policy and Procedure Manual.

3.Post-Falls Management Policy was reviewed and does not include home specific interdisciplinary procedures to follow to prevent further falls, when a resident identified at high risk for falls/injury, experiences repeated incidents of falling without injury or hospitalization.

4.Interview with a senior staff member indicated the written need for side rails or any safety device should be documented on the care plan. It was further reported that there are no policies and procedures developed in the home related to the use of resident personal bed or chair alarms used as a safety device to prevent falls or guidelines for staff to follow if the alarms are malfunctioning.

5.Care Plan for resident #1 at high risk for falls, with multiple risk factors was reviewed and indicated two half/assist rails and a nurse call bell, both safety devices, were not identified on the resident's care plan as a falls prevention intervention although they were reported to be in use.

6.Resident #1's health record including progress notes by RPNs was reviewed and indicated that resident #1 fell from the bed to the floor, four times prior to the Critical Incident.

7.Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes.

8. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four times in six months.

9.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had a fall during the review period. The resident's care plan indicated that the resident's continence status triggered the resident climbing out of bed. Resident #1's care plan was reviewed but not revised to include the resident's deteriorating continence status and potential implication for risk of falls.

10.Interview with an identified physician, confirmed resident#1's fall from bed was implicated in a Critical Incident resulting in death. (175)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee of the long term care home shall develop and implement a plan to ensure that s. 19 is complied with and that all residents in the home are not neglected by the licensee and staff of the home.
The plan shall include, but not be limited to, the development of a specific, interdisciplinary process for management of Critical Incidents.The process shall include analysis and follow up action to mitigate risk to residents and prevent recurrence of harm.

Grounds / Motifs :

1. 1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety, or well-being of one or more residents.

The following occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well-being of resident #1 related to the identified Critical Incident resulting in death:

1.Resident #1 risk for falls was identified by the home as being characterized by multiple risk factors.Interventions on the resident's care plan included that staff will ensure the bed alarm is functioning properly.Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning as it did not sound to alert staff resident was climbing out of bed.There was no documentation or staff report of any action taken by staff to communicate the malfunctioning alarm in the Maintenance Book, or ensure that the resident had a functioning safety device related to falls prevention. On the day of the Critical Incident, there was no bed alarm device provided to resident #1,in the resident's room.

2.Interview with a senior staff member confirmed that prior to the Critical Incident of resident #1, a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them.The senior staff member reported that 1 staff member only was re-directed to the location of the re-set button.The senior staff member further reported that use of resident Personal Alarms in the home is not documented anywhere. The process is verbal, not written. There are no policies and procedures for the use of resident personal bed or chair alarms used as a safety device for falls prevention. Staff who unplugged/removed resident personal alarms neglected to priorize resident safety needs and jeopardized the health and safety of resident #1 and other residents identified to require personal alarms. Senior staff members neglected to communicate the need for all staff to receive education and training related to the correct/safe use of resident personal alarms as a safety device for residents, neglected to ensure that a policy and procedure for the use of personal alarms as a safety device for residents was developed and communicated to staff, neglected to ensure there was a system in place to monitor and maintain resident personal alarms as a safety device for resident #1.

3.Resident # 1's care plan indicates that resident#1's primary trigger for high risk for falls was related to continence issues. Staff interventions related to risk for falls include staff are to provide specific care. Resident#1 is also identified with a specific communication deficit related to a known medical condition. Interventions include staff are to provide daily routine to meet activities of daily living. The day of the Critical Incident, interviews with staff confirmed that resident #1 resident who had specific known communication deficit, was left, in bed, with the bed at an unsafe height, and without call bell access or a personal bed alarm to call staff for help or alert staff to the movement of the resident in bed.

4.Nursing progress notes indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions. The day of the Critical Incident, staff neglected to manage the resident's known continence needs related to risk for falls. Registered nursing staff neglected to monitor resident#1 to ensure that effective continence care was provided to resident #1.

5.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls.

6.The Falls Management Program currently in the home, directs all staff to follow the Policies and Procedures in the Physio Manual. Physio Quarterly re-assessment reviewed, indicates that resident #1's risk of falls was "not applicable" and not assessed. Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced 2 falls from the bed, for the relevant time period, that were documented on the resident #1's nursing progress notes. A second Physio Assessment reviewed, indicates incorrectly that resident #1 fell 1-2 times, while a review of resident nursing Progress notes from date of admission indicated that resident #1 had fallen from bed four times in six months. Physio staff neglected to correctly assess resident #1's risk for falls, to monitor the incidence of falls for resident #1 and to initiate a falls prevention program for resident #1 that could be shared with all other disciplines in the home, so resident #1's risk of falls could be managed/reduced.

7.Review of resident #1's health record indicated the bed rails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. Registered Nursing staff neglected to follow the home's Policy and Procedure Bed and Assist Rails for resident #1 which directs staff to complete a needs assessment for the use of assist rails and staff engaging the side rails will ensure the resident's call bell is accessible to resident. Registered staff neglected to develop a plan of care for the use of assist rails, which includes the reason for their use, for resident #1. There were no specific directions regarding a call bell for resident #1. Specific directions were not provided for staff related to the use of side rails/assist rails.Registered nursing staff neglected to re-assess the use of assist rails for resident #1 after each of the four falls prior to the Critical Incident resulting in death.

8.Registered nursing staff repeatedly neglected to re-assess the falls risk of resident #1 according to RAI assessment done for a specific time frame. No re-assessment observed related to resident #1's falls risk despite the fact that nursing Progress Notes for that time period indicated resident #1 had a fall.Review of RAP MDS Quarterly Assessment on a specific date indicated "No falls since the last identified quarter, which was incorrect, as resident#1 had experienced two falls in the identified time period. An RN documented a monitoring note for resident #1 medications and some health conditions, however,there was no re-assessment observed for resident #1's falls risk, indicating the resident's falls risk was not being monitored by nursing staff.

9.Interview with an identified Physician confirmed resident#1's fall from bed was implicated in the Critical Incident resulting in death.

The following occurrences demonstrate a pattern of inaction by the home that jeopardized the health, safety and well-being of other residents in the home post Critical Incident.

10.Interviews with a senior staff member confirmed that there is no facility specific, interdisciplinary process in place to guide the management of Critical Incidents involving residents.

11.Interview with a second senior staff member confirmed there was no review/investigation of resident #1's health care record, post fall, resulting in a Critical Incident and death, as part of the follow-up analysis to identify immediate corrective actions to prevent recurrence and protect other residents living in the home from potential harm/risk of harm.

12.Two senior staff members confirmed that the staff did not have the call bell pad pinned or clipped to resident#1 on the day of the Critical Incident.

13.Eight days post Critical Incident, a Memo to staff re ensuring all residents call bell access was sent to staff in all resident home areas.

14.Post Critical Incident interview with a senior staff member, confirmed that resident#1 did not have a personal alarm on the day of the Critical Incident resulting in resident death. The senior staff member reportedly did not know why the resident did not have a personal alarm. Immediate action was not taken to ensure the provision of resident personal alarms, reported to be a safety device in use in the home for residents identified at high risk for falls.

15.Care Plan review eight days post Critical Incident, for resident #2 specified that this resident is at risk for falls characterized by multiple risk factors. Interventions directed that staff will put bed alarm in place to alert staff so they can assist resident #2 whenever the resident is non-compliant in asking for staff assist.

16.Interview with a registered staff member indicated that the staff member was not aware of the personal alarm currently being used for resident #2, but knew it was supposed to be there.The registered staff member neglected to ensure resident #2 had a personal alarm in place to alert staff and manage the resident's high risk for falls.

17.Observation of resident #2 Room with a second Registered nursing staff member, confirmed the mechanism for a personal alarm on the head of the bed was not there. The Registered nursing staff member further reported that resident #2's plan of care says the resident is to have a bed alarm but that a while ago staff could not turn the personal alarms off- they were ringing when there was no need for them to be ringing. The only way to turn them off was disconnect them from the jack outlet at the base. Resident #2 was confirmed by staff not to be provided with a bed alarm for more than 3 months. Registered nursing staff on all shifts, including senior nursing staff, repeatedly neglected the identified safety need of Resident #2 for more than 3 months, when staff knew resident #2 was not provided with a bed alarm to address falls risk, as specified in the plan of care.The senior staff neglected to take immediate action to ensure that all residents identified at high risk for falls in the home, had a functioning personal alarm if the care plan of the resident(s) indicated it was an assessed safety need.Immediate corrective actions were not implemented to ensure that identified deficiencies regarding resident personal alarms were fully addressed.

18.Interview with an identified physician confirmed a plastic bag/garbage can insert was implicated in the Critical Incident resulting in resident death.

19.Senior staff confirmed that a decision was made, not to discontinue the use of the same plastic bag insert in resident garbage cans based on this one situation in all the years that the home had used that particular plastic bag insert would be overreacting.The decision was reportedly based on hygiene and infection control issues, not based on potential risk of harm to residents.

20.Interview with senior staff member confirmed that there are two cognitively impaired, ambulatory residents currently in the home, specifically identified at risk for injury (Resident #3 and Resident #4) due to a related medical diagnosis. Observation of an identified Resident Home Area confirmed garbage cans with plastic bag inserts were observed to be accessible to several confused, ambulatory, wandering residents, including residents #3 and 4, in all resident bathrooms.Senior Management staff neglected to take immediate action to limit access to any and all residents in the home with the potential risk for harm related to the known circumstances of the Critical Incident resulting in resident death. (175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

the licensee shall ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident

Grounds / Motifs :

1. 1. Review of Health Care Record including Care Plan for resident #1 indicates resident #1 had a high risk for falls due to multiple factors. There were no clear directions to staff regarding nurse call device or the use of side rails/assist rails.

2.Interview with senior staff member confirmed the written need for side rails or any safety device should be documented in the resident care plan.

3.Interviews with two staff, indicated that for resident #1 the call bell pad and side rails/half rails, were always in use.

4.Interview with another staff member indicated resident #1 had identified communication deficits.It was further reported that the staff member could not remember giving resident #1 the call bell the day of the Critical Incident resulting in resident death.

5.Interview with a registered nursing staff member indicated side rails/ half rails were always in use for resident #1.

6.Interview with senior staff members indicated that the staff did not have resident #1 call bell pinned or clipped to the resident. (175)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Order # / Ordre no : 006 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

the licenss shall ensure that all residents are re-assessed and their plans of care reviewed and revised at least every six months and at any other time when (c)care set out in their plans has not been effective.

Grounds / Motifs :

1. 2. 1.Care Plan review for resident #1 identifies the resident was at high risk for injury/falls and indicates that the resident had a bed alarm in place on the bed.Interventions included that staff will ensure the bed alarm is functioning properly.

2.Nursing staff documented in the resident progress notes that on three occasions prior to the Critical Incident, staff witnessed that the resident had already fallen from the bed to the floor. There was no nursing documentation indicating the registered nursing staff acted to ensure the resident's personal alarm was functioning. In each incident, the resident had already fallen. A fourth fall from the bed to the floor was documented in nursing progress notes and indicated resident #1 was found and the bed alarm was not functioning. On the day of the Critical Incident resulting in resident death, there was no bed alarm device provided to resident #1.

3.Interview with a senior staff member, confirmed that about 6 months ago a staff member working in the home complained that resident personal alarms were too sensitive, staff did not know how to turn them off, so they unplugged them.

4.The personal alarm care intervention was not effective in alerting staff of the resident's increased movement prior to experiencing a fall.The resident's needs related to high fall risk were not re-assessed and the care plan was not reviewed and revised when the resident's personal alarm was not effective.

5.Resident #1's care plan indicates the resident's continence issue is identified as the primary risk trigger for falls.Nursing progress notes reviewed, indicated that interventions to manage the resident's incontinence, to minimize the risk of falls, were not effective in prevention of falls on at least four occasions prior to the Critical Incident. Registered nursing staff neglected to manage the resident's continence needs to reduce the risk of falls.

6.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and that the resident had fallen within the time frame being assessed. The resident's care plan was reviewed but not revised when the interventions to manage the resident's continence needs were ineffective.

7.Nursing progress notes were reviewed and indicated the resident fell from bed four times prior to the Critical Incident. The bedrails for resident #1, reported to be half rails, one on either side of the bottom half of the bed, were not effective care interventions to manage the resident's high risk for falls. There was repeatedly no documentation or report of any re-assessment of resident #1's safety needs related to the ongoing use of half rails.

8.Interview with identified Physician confirmed that the side rails/half rails were implicated in the Critical Incident resulting in the death of resident #1.

9.Physio Quarterly re-assessment was reviewed and indicates the resident risk of falls was "not applicable" and not assessed.Physio did not have the resident on a Falls Prevention Program despite the fact that Resident#1 experienced falls from the bed, documented on the nursing progress notes.
A second Physio Assessment, indicates incorrectly that resident#1 fell 1-2 times in a six month period. Review of resident Progress notes indicate resident#1 fell from bed four times in six months.

10.Nursing RAI MDS Quarterly Assessment identified that resident #1's continence status had deteriorated and the resident had fallen. Registered Nursing staff neglected to revise resident #1's plan of care related to high risk for falls and the impact the resident's deteriorating continence status had on further increasing the risk for falls. (175)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto ON M5S 2B1
Fax: (416) 327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075 rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075 rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur: (416) 327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of August, 2012

Signature of Inspector / Signature de l'inspecteur : B Thompson

Name of Inspector / Nom de l'inspecteur : BRENDA THOMPSON

Service Area Office / Bureau régional de services : Ottawa Service Area Office