Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 19, 2014	2014_323130_0009	H-000688-14	Resident Quality Inspection

Licensee/Titulaire de permis

THE CENTRAL CANADIAN DISTRICT OF THE CHRISTIAN AND MISSIONARY ALLIANCE IN CANADA
155 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

CAMA WOODLANDS NURSING HOME
159 PANIN ROAD, BURLINGTON, ON, L7P-5A6

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

GILLIAN TRACEY (130), CATHY FEDIASH (214), KELLY HAYES (583)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): June 9, 10, 11, 12, 13 and 16, 2014.

Please note the following follow-up inspection was conducted simultaneously with this inspection: H-0009314-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, registered staff, Resident Assessment Instrument (RAI) Coordinator, personal support workers, Food Service Supervisor, dietary staff, Enterostomal Nurse (ET), maintenance staff, residents and families.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that set out, (a) the planned care for the resident and (b) the goals the care was intended to achieve.

a) Resident #102 was observed on three identified dates in 2014, and noted to have a dressing applied to an identified area. Staff interviewed confirmed the alteration in skin was not included in the plan of care, there were no interventions in place for managing the area nor was there a plan in place for the prevention of further alterations in skin. (130)

b) Resident #200 was observed to have a restraining device in place, while in their wheelchair. A review of the resident's written plan of care had not identified the use of the device. An interview conducted with registered staff indicated that the device was used daily when the resident was up in their wheelchair as this was a preference of the resident and made them feel safe. Registered staff confirmed that the use of the device had not been included in the resident's written plan of care. [s. 6. (1) (a)]

2. The licensee did not ensure that the care set out in the plan of care was provided to

the resident as specified in the plan.

a) The plan of care for resident #102 indicated the resident was at risk for falls, and for toileting required one person constant extensive supervision and physical assistance for safety with use of a mechanical sit to stand lift. On an identified date in 2014, the resident was observed seated on the toilet, with the mechanical lift safety harness attached the the lift. The DOC confirmed the resident should not have been left unattended on the toilet.(130) [s. 6. (7)]

3. The licensee did not ensure that residents were reassessed and that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

a) A review of resident #500's plan of care indicated they had a restraining device. A record review of #500's plan of care over a five month period in 2014, identified that a restraint assessment had not been completed. In an interview with the Director of Care it was confirmed that the restraint assessment had not been completed during resident #500's 2014 annual assessment and that a restraint assessment had not been completed within the past six months. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out, (a) the planned care for the resident and (b) the goals the care is intended to achieve, that the care set out in the plan of care is provided to the resident as specified in the plan and that residents are reassessed and the plan of care is reviewed and revised at least every six months and at any other time when the residents care needs change or when care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with .

The home's policy, Fall Risk Assessment (08-12-02) indicated that all residents were to be assessed regarding risk of falling upon admission, quarterly, and whenever there was a significant change of condition. The resident care plan would be updated to reflect their fall risk status. The Policy and Procedure Falls Prevention and Management (08-14-01) indicated that a post fall investigation report would be completed following each resident fall, and resident would be monitoured for 48 hours after a fall if they were on anticoagulants such as coumadin.

a) A review of resident #103's clinical record indicated that there were no fall risk assessments completed from over a seven month period from 2013 to 2013, at which time the resident was identified as a risk for falls. There were no post fall investigation reports completed for falls which occurred on four occasions from 2013 to 2014. According to the medication administration record, the resident was received anticoagulant therapy during the same time period. The resident was not monitored for 48 hours after falls which occurred on three of the four occasions. This information was confirmed by registered staff. (130)

b) A review of resident #200's clinical records indicated that a Fall Risk Assessment was last completed on a specific date in 2014. The resident had sustained a fall two months after the assessment was completed; their written plan of care had not identified their current fall risk level. An interview conducted with registered staff confirmed that the Fall Risk Assessment had not been completed quarterly and that the written plan of care, that the home calls the Resident Care Plan, had not identified the residents fall risk level.

The home's Pressure Ulcer Risk Assessment (07-02-02) indicated a Braden Scale assessment was to be completed in computerized Point Click Care database upon admission, readmission, quarterly or whenever a significant change in condition occurred.

a) According to the clinical records, resident #101, #102 and #103 did not have Braden Skin Risk Assessments completed quarterly as required by policy. This information was confirmed by the DOC. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

a) The quarterly minimum data set (MDS) assessments completed for resident #101 on two identified dates in 2014, indicated the resident was incontinent of bowel and bladder. Registered staff confirmed the plan of care did not identify the resident's continence status, goals or interventions to manage the incontinence.

b) The quarterly MDS assessments completed for resident #503 on two identified dates in 2014, indicated the resident was incontinent of bowel and bladder. Registered staff confirmed the plan of care did not identify the resident's continence status, goals or interventions to manage the incontinence.

c) The quarterly MDS assessments completed on an identified date in 2014, for resident #103, indicated the resident was usually continent of bladder and continent of bowel. Registered staff confirmed there were no established goals or interventions for the management of bowel and bladder continence.

d) The quarterly MDS assessment completed on an identified date in 2014, for resident #202, indicated that the resident was frequently incontinent of bowel. A review of this resident's written plan of care, indicated that they did not have a plan of care that identified the resident's continence status in relation to bowel elimination. An interview conducted with registered staff confirmed that the plan of care did not identify the resident's continence status, goals, or interventions in relation to their bowel elimination. [s. 26. (3) 8.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's plan of care is based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

a) Registered staff confirmed that medication packages, which contained residents' names and medication regimes, were discarded with the general garbage and not disposed of in a manner which would protect the residents' personal health information. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director.

a) On an identified date in 2014, resident #102 was involved in an altercation with a co-resident which resulted in an injury. The DOC confirmed the incident of abuse was not reported to the Director as required. [s. 24. (1) 2.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

a) During a staff interview, it was noted that resident #202 had sustained a fall on an identified date in 2014. A review of the resident's clinical record indicated that the incident and the assessment of the resident had not been documented. An interview with registered staff confirmed that the incident and the assessment had not been documented in the resident's clinical record. [s. 30. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee did not ensure the restraint plan of care included alternatives to restraining that were considered, and tried, but were not effective in addressing the risk.

a) A review of resident #500's plan of care indicated they had a restraining device in place. A review of the clinical record indicated there was no documentation that identified alternatives to restraining. In an interview with registered staff it was confirmed that alternatives to restraining had not been considered. [s. 31. (2) 2.]

2. The licensee did not ensure a physician, registered nurse in the extended class or other persons provided for in the regulations ordered or approved the restraining.

a) A review of resident #500's plan of care indicated they had a restraining device applied. According to the Physician Medication Review completed during an identified time period, there was no order for the device. In an interview with the registered staff it was confirmed that the restraints were not ordered or approved by a nurse in the extended class or a physician for resident #500. [s. 31. (2) 4.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions and was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence where the condition or circumstances of the resident required.

a) The quarterly MDS assessment completed for resident #101 on an identified date in 2013, indicated the resident was continent of bowel and frequently incontinent of bladder. The quarterly MDS assessment completed on another date in 2014, indicated the resident was frequently incontinent of bowel and incontinent of bladder. The quarterly MDS assessment completed later in 2014 indicated the resident was incontinent of bowel and bladder.

b) The quarterly MDS assessment completed for resident #503 on an identified date in 2014, indicated the resident was frequently incontinent of bowel and occasionally incontinent of bladder. The MDS assessment completed later in 2014, indicated the resident was usually continent of bowel and occasionally incontinent of bladder.

c) The quarterly MDS assessment completed for resident #202 on an identified date in 2013, indicated the resident was frequently incontinent of both bowel and bladder. The quarterly MDS assessment completed later in 2013, indicated the resident was incontinent of both bowel and bladder. The quarterly MDS assessment completed on a specific date in 2014, indicated the resident was frequently incontinent of bowel and incontinent of bladder. Registered staff confirmed the residents were not assessed using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence when the residents' continence status had changed. [s. 51. (2) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that there was at least quarterly, a documented reassessment of each resident's drug regime.

a) Resident #102 did not have a quarterly medication review by the physician during a specific time period in 2014. This information was confirmed by registered staff. [s. 134. (c)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 110. (1)	CO #001	2013_190159_0032	130

Issued on this 19th day of June, 2014

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