Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2020	2020_704682_0001	014582-19, 016285-19	Critical Incident System

Licensee/Titulaire de permis

Clarion Nursing Homes Limited
337 Highway #8 STONEY CREEK ON L8G 1E7

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

Clarion Nursing Home
337 Highway #8 STONEY CREEK ON L8G 1E7

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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 2, 6, 8, 2020.

The following Critical Incident System inspection(s) were conducted:
014582-19 related to injury and significant change
016285-19 related to injury and significant change

During the course of the inspection, the inspector(s) spoke with the Director of Care, Relief Director of Care, Registered nursing staff, Personal support workers, and residents.

During the course of this inspection, the inspector observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, meeting minutes and policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

s. 6. (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 failed to ensure that resident #002 was reassessed and the plan of care reviewed and revised when the resident’s care needs change.

A Critical Incident (CI) was submitted to the Director.

A progress note indicated resident #002 had sustained an injury and was transferred for further medical intervention. A progress note identified resident #002 was re-admitted to the home. Further review did not find any assessments/ reassessments, or any evidence that the plan of care was reviewed and revised related to resident's #002 change in condition.

On an identified date, a request was made by Inspector #682 for the licensee to provide copies of 'all' assessments/reassessments done for resident #002 within an identified time frame. The DOC confirmed that the assessments were not in the clinical record. The relief Director of Care (RDOC) provided two reassessments to the Inspector.

During a telephone interview, the DOC stated they expected staff to reassess and review and revise the plan of care for resident #002 when they had a change in condition. The DOC confirmed that the reassessment was not included and not provided when the Inspector requested the documentation. During the time of the inspection, the DOC could not provide evidence that the staff reassessed resident #002 or that they reviewed and revised the plan of care when their care needs changed.

The home home did not ensure resident #002 was reassessed and the plan of care reviewed and revised when the resident's care needs changed. [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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or 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. 232. Every licensee of a long-term care home shall ensure that the records of the residents of the home are kept at the home. O. Reg. 79/10, s. 232.

Findings/Faits saillants :

1. The licensee failed to ensure that the records of the residents of the home were kept at the home.

A Critical Incident (CI) was submitted to the Director.

A clinical record review of resident's #002 clinical record could not find any assessments/reassessments within an identified time frame.

During a telephone interview, staff #108 confirmed that they documented their assessments electronically in the progress notes section of the clinical record. During an interview, the DOC confirmed that they could not find any assessments/ reassessments documented in resident #002 clinical record. The DOC investigated and consulted staff #108 and stated that the staff documented their assessments in their own files which was not at the long term care home at the time of the inspection. The home did not ensure that the records of resident #002 were kept in the home. [s. 232.]

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 records of the residents of the home are kept at the home, to be implemented voluntarily.

WN #3: 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. A) The licensee failed to ensure that interventions related to reassessments for resident #002 completed by registered staff were documented.

A Critical Incident (CI) was submitted to the Director, related to resident #002.

A review of resident's #002 care plan, indicated that the resident was assessed and required assistance with transfers. A progress noted identified that resident #002 had responsive behaviours on an identified date. Resident #002 was transferred by staff #102 and staff #101. A progress noted, identified resident #002 had sustained an injury.

During an interview, staff #102 stated that resident #002 exhibited responsive behaviours. Staff #102 also stated that they transferred the resident. The DOC confirmed that the reassessment of transfer status related to the incident was not documented by the registered staff. The home did not ensure that actions taken with respect to a resident, including reassessments related to mode of transfer were documented.

B) The licensee failed to ensure that reassessments related to mobility and transfer status for resident #002 completed by staff were documented.

A clinical record review included a progress note that indicated resident #002 had sustained an injury. Further review included a progress note staff #109 identified that resident #002 required an assessment. A review of the clinical record could not find any assessments.

During an interview, staff #108 confirmed their hours worked in home and their assessments were documented electronically. During an interview the DOC confirmed that they expected the staff to document their assessments. The DOC confirmed that there was no documentation. The home did not ensure that actions taken with respect to resident #002, including assessments and reassessments were documented. [s. 30. (2)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for resident #002 demonstrating responsive behaviours, actions were taken to respond to the needs of resident #002, including interventions and resident's responses to interventions were documented.

A clinical record review identified resident #002 had responsive behaviours on an identified date. Resident's #002 care plan included various strategies/ interventions to manage responsive behaviours.

A progress note identified that resident #002 exhibited responsive behaviours. Further review did not find any documentation related to strategies/ interventions attempted to minimize resident's #002 responsive behaviours. A progress note indicated that resident #002 had sustained an injury.

During an interview, staff #102 reported that resident #002 exhibited responsive behaviours. During an interview, the DOC stated that interventions to manage resident #002 responsive behaviours and resident's responses were implemented but not documented. The home did not ensure that resident #002 demonstrating responsive behaviours, actions were taken to respond to the needs of resident #002, including interventions/strategies and resident's responses to interventions were documented. [s. 53. (4) (c)]

Issued on this 21st day of January, 2020

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

Original report signed by the inspector.