Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 11, 12, Jul 18, 19, 27, 31, 2012	2012_061129_0005	Critical Incident

Licensee/Titulaire de permis

DEEM MANAGEMENT SERVICES LIMITED
2 QUEEN STREET EAST, SUITE 1500, TORONTO, ON, M5C-3G5

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

HAMILTON CONTINUING CARE
125 WENTWORTH STREET SOUTH, HAMILTON, ON, L8N-2Z1

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, acting Director of Care, regulated and unregulated staff related to log # H-000362-12

During the course of the inspection, the inspector(s) toured the home, reviewed clinical record documents, reviewed interview notes collected by the home and reviewed the home's policy and procedures.

The following Inspection Protocols were used during this inspection:

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	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee did not ensure that there was a written plan of care for each resident that sets out clear directions for staff and others who provide direct care to the resident, with respect to the following: [6(1)(c)]
a) Resident # 1 experienced a fall which resulted in an injury and significant deterioration in the resident's condition. Documentation in the clinical record indicated the resident required bed rest, was experiencing increased pain and required end of live care. Although the changing needs of the resident were being assessed the directions for front line staff providing care were not clear. The acting Director of Care (DOC) confirmed that the document in the home that provides the direction to staff who provide direct care to the residents is the care plan document which is created in a computerized version and then copied to ensure that unregulated staff providing care to residents who do not access the computer are made aware of the care they are to provide to residents. Staff confirmed that this document did not provide clear direction to staff providing care, related to:
-care to be provided by front line staff to a bed ridden resident with respect to positioning, care related to managing an increase risk of skin breakdown, continence care, bathing, and activation.
-care to be provided by front line staff to a resident who is experiencing increased pain and who requires end of life care.
b) Documentation in resident #2's clinical record indicated that the resident began to demonstrate increased responsive behaviours during the evening hours, was noted to be wandering into other resident's rooms, had an upper respiratory infection, was placed on fluid replacement therapy and was receiving a narcotic analgesic as a comfort measure. Staff confirmed that the care plan did not contain clear direction for staff responsible for providing direct care, with respect to the following:
-care, staff was to provide in order to manage responsive behaviours.
-care, staff was to provide to a resident with an upper respiratory infection.
-care for a resident experiencing dehydration and receiving fluid replacement therapy.
-care for a resident who has been designated as requiring end of life care.

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 and ensuring that 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, to be implemented voluntarily.

WN #2: 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 subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee did not ensure that staff who had reasonable grounds to suspect that abuse of a resident by a co-resident had occurred immediately reported this suspicion and the information which it was based on to the Director, in relation to the following: [24(1)(2)]
- Registered staff in the home had reasonable grounds to suspect that physical abuse had occurred when staff found resident #1 sitting on the floor of her room in pain. At the time of this incident the resident reported to staff that resident #2 actions resulted in injuries to a co-resident. Staff confirmed that resident #1 had never been untruthful in her recounting of incidents in the past.
- Staff did not immediately use the after hours pager to notify the Director and did not initiate the online Mandatory Critical System (MCIS) for more than 18 hours following the incident.

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 and ensuring that a person who has 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 the resident has occurred or may occur, shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: 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. The licensee did not ensure that where the Act or Regulation requires the licensee 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 is complied with, regarding the following: [8(1)(b)]

The home's policies included in the Nursing and Personal Support Program related to responsive behaviours were not complied, specifically:
a) The Responsive Behaviours policy # 09-05-01 dated September 2012 directs that a resident focused care plan will be developed and maintained that includes triggers to the behaviours, preventative measures to minimize the risk of behaviours developing or escalating, resident specific intervention to address the behaviours and strategies staff are to follow if the interventions are not effective. Staff in the home did not comply with these directions when they did not develop and maintain a care plan for resident #2 who was demonstrating responsive behaviours, that included the triggers for the identified behaviours, preventative measures to prevent the behaviours from escalating and resident specific interventions. The acting DOC confirmed that resident #2's plan of care did not include the required information and measures. The resident's behaviour escalated and it was reported that this resident's actions resulted in an injury to a co-resident.
b) The above noted policy also indicates that staff are responsible for completing accurate documentation in the resident's health record or on the Responsive Behaviour Record. Staff in the home did not comply with this responsibility when they did not document the above noted events in resident #2's clinical record nor did they implement the Responsive Behaviour Record.
c) The Responsive Episode Debriefing policy #09-05-02 dated September 2012 directs staff that following a new or escalated responsive behaviour episode, the interdisciplinary team is to review the episode and debrief looking for proactive steps the team can take to minimize the risk of recurrence. The acting DOC confirmed and the clinical record indicates that an interdisciplinary team did not conduct a debriefing session for the incident noted above in order to attempt to minimize the risk of another altercation between resident #2 and other co-residents.

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 and ensuring that 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 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations and identifying and implementing interventions, with respect to the following.
Staff was aware and it is documented in resident #2's clinical record that the resident was demonstrating increasing responsive behaviours during the evening hours and continued to wander into co-residents rooms. Staff also confirmed that they believed that resident #2 had on previous occasions been aggressive with the roommate, although no incidents were documented in the clinical record. Staff in the home confirmed that during the period of time when they were making observations about the changing behaviours being demonstrated by the resident, an interdisciplinary assessment was not conducted nor did they analyse the observations made by frontline staff with respect to the resident's behaviours. Staff also confirmed and the clinical record indicated that interventions were not identified or implemented that would minimize the risk of altercations between residents. It was reported that resident #2's action resulted in an injury for a co-resident.
Following the incident, staff from an outside agency visited the home assessed the resident, identified possible triggers for behaviours being demonstrated and made recommendations for interventions to manage these responsive behaviours and prevent further altercations between residents. These recommendations were not made part of the resident's health record, staff confirmed they had no knowledge this assessment or the recommendations and as a result the recommendations were not implemented.

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 and ensuring that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observations, that could potentially trigger such altercations and identifying and implementing interventions, to be implemented voluntarily.

Issued on this 31st day of July, 2012

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