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
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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
Dec 4, 2013	2013_214146_0063	H-001964-12	Critical Incident System

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

BARBARA NAYKALYK-HUNT (146)

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): November 20, 21, 22, 25, 2013

This inspection was conducted concurrently with complaint inspection 2013-214146-0064 for H-000750-13, H-000610-13 and H-000305-13. Areas of non-compliance common to both inspections, specifically skin and wound care, will be addressed on report 2013-214146-0064.

During the course of the inspection, the inspector(s) spoke with the administrator/Director of Care (DOC), environmental and program manager, Resident Assessment Instrument (RAI) coordinator, registered staff, Personal Support Workers (PSW'S), residents and family members.

During the course of the inspection, the inspector(s) toured the home, reviewed policies related to skin care, wound management, pain management and reviewed the home's complaint log and resident health records.

The following Inspection Protocols were used during this inspection:
Pain

Skin and Wound Care

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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
4. Customary routines and comfort requirements. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
5. Drugs and treatments required. O. Reg. 79/10, s. 24 (2).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the care plan included, at a minimum, the following with respect to the resident: 4. Customary routines and comfort requirements.
Resident #006 was admitted to the home in August 2012 after a recent hospitalization. Even though the resident complained of pain on the day of admission, the care plan did not include pain or comfort requirements until 10 days later. This information was confirmed by the health record, the DOC and the home's internal investigation notes. [s. 24. (2) 4.]

2. The licensee did not ensure that the care plan included, at a minimum, the following with respect to the resident: 5. drugs and treatments required.
Resident #006 was admitted to the home in August 2012. The transfer records that accompanied the resident indicated that the resident required treatment to be done daily. This treatment was not included in the admission care plan. This information was confirmed by the health record, the RAI coordinator and the notes of the home's internal investigation. [s. 24. (2) 5.]

3. The licensee did not ensure that the care plan included, at a minimum, the following with respect to the resident: 7. Skin condition, including interventions.
Resident #006 was admitted to the home in August 2012. No admission head to toe assessment was completed until 10 days later. This information was confirmed by the health record, the DOC and the home's internal investigation notes. [s. 24. (2) 7.]

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 24-hour admission care plan identifies the resident and must include, at a minimum, the following with respect to the resident: (4) customary routines and comfort requirements; (5) drugs and treatments required; and (7)skin condition, including interventions, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee did not ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.
Resident #006 was admitted to the home in August 2012 with a wound as noted by the admitting nurse. In August 2012, the dietitian documented that the resident's skin was intact and made no mention of the wound. Five days after the dietitian's assessment, progress notes stated that the wound had deteriorated. The nursing and dietary assessments were conflicting rather than collaborative. This information was confirmed by the health record and the RAI coordinator. [s. 6. (4) (a)]

Issued on this 17th day of December, 2013

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

BARBARA NAYKALYK