Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Sep 23, 2019	2019_543561_0024	005053-19, 015510-19	Complaint

Licensee/Titulaire de permis

Unger Nursing Homes Limited
75 Plains Road West BURLINGTON ON L7T 1E8

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

Hampton Terrace Care Centre
75 Plains Road West BURLINGTON ON L7T 1E8

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

DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 12, 13, 16, 17, 18, 19, 2019.

The following Complaint Intakes were completed during this inspection:
log #005053-19 - related to multiple care areas,
log #015510-19 - related to multiple care areas.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Dietary Manager, Registered Dietitian (RD), physician, Clinical Quality Improvement (CQI) Coordinator, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

During the course of the inspection, the inspector: toured the home, observed provision of care, observed meal services, reviewed clinical records, reviewed policies and procedures, dietary menus, seating plans, reviewed the complaints binder, and any other relevant documentation pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 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. (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 failed to ensure that the care set out in the plan of care for resident #001 was provided to the resident as specified in the plan.

A) The plan of care for resident #001 identified an intervention for the resident's condition. The Electronic Medication Administration Record (EMAR) for an identified month in 2019, was reviewed and the staff had been documenting that the intervention was being applied at 1000 hours. The resident was observed on two identified days in September 2019, and the intervention was not applied on those dates as indicated in the plan of care.

Interviewed RPN #105 who documented the care as being provided and stated that the identified intervention was not being applied as it was not feasible to do it at the time indicated in the EMAR. Interviewed PSW #106 who provided direct care to the resident and stated that the identified intervention was not being applied.

The DOC confirmed that the resident had the order for the intervention and regular staff were following the plan of care.

B) Resident #001 had a plan of care indicating that they required an intervention related to personal care at specified times of the day. Inspector #561 observed the care for the resident on five different days in September 2019. On two different days of the observation, the Inspector observed that the care was not provided to the resident as specified in the plan of care.

PSW # 102 who provided direct care to the resident was interviewed and confirmed the specified intervention was to be provided on specified times of the day. The PSW stated that they did not provide the care on the identified date in 2019. On a different day in 2019, at approximately 1000 hours, the Inspector checked the device used for personal care and it looked as if it was not used that day. The DOC stated the plan of care for resident #001 indicated that resident required the identified intervention at specified times of the day.

The licensee failed to ensure that care set out in the plan of care related to interventions required were not provided to resident #001 as indicated in the plan of care.[s. 6. (7)]

2. The licensee failed to ensure that resident was 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 changed or care set out in the plan was no longer necessary.

The plan of care for resident #004 was reviewed and stated that resident required an intervention for a health condition; however, it did not fit the resident. A progress note indicated that staff tried to apply a different intervention which was tolerated well by the resident and the staff left a message for the physician to obtain an order for it. There was no evidence that the order was obtained and whether the intervention was being applied. RN #115 was interviewed and stated that for the application of the identified intervention the home required an order from the physician and then this intervention would have been added in the EMAR or electronic Treatment Administration Record (ETAR). If the physician was called and the message was left the staff needed to follow up or write it in the doctor's book for the next physician visit. The communication book pages were not being kept as the physician would shred them after each visit a indicated by the physician.

The physician was interviewed and stated if the staff called to obtain the order they would have written the order for the identified intervention. They could not recall receiving a message from the home. The physician stated they had the doctor's day on Fridays, and if this was added to the communication book the order would have been written.

The licensee failed to ensure that the plan of care was reviewed and revised when the resident required application of a new intervention for the identified health condition. [s. 6. (10) (b)]

WN #2: 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 failed to 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.

The plan of care for resident #004 indicated that resident had an identified diagnosis, was on a specified diet and were to be monitored during meals.
Documentation made by RN #111 on an identified date in 2019, indicated that they were called to assist the resident due to a change in condition. The RN called the physician and they ordered an intervention and if resident did not respond to that, they were to send the resident to the hospital. The intervention was not successful, and the resident was send out to the hospital for further treatment.

RPN #108 was interviewed and stated they worked directly on the unit where resident resided on the date of when the resident had the change in condition in 2019. The RPN was in the dining room assisting and monitoring residents during a meal. They stated that after the meal they noticed that resident was not well. The RPN stated that they called the RN to assist and the RN called the physician for guidance. Soon after the resident was sent out to the hospital. The RPN stated that they failed to document their assessment.

The plan of care was reviewed and identified that the initial assessment of the resident was not documented by the RPN #108.

The licensee failed to ensure that the assessment and interventions were documented by RPN on June 30, 2019. [s. 30. (2)]

Issued on this 24th day of September, 2019

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

Original report signed by the inspector.