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
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

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 24, 25, 29, Sep 7, Oct 6, 17, Nov 24, 30, 2011	2011_065169_0013	Complaint

Licensee/Titulaire de permis

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

HERITAGE GREEN NURSING HOME
353 ISAAC BROCK DRIVE, STONEY CREEK, ON, L8J-2J3

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

YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Directors of Care, Registered staff, Personal Support Workers, residents and families.

During the course of the inspection, the inspector(s) Reviewed the clinical records, observed care areas, observed residents and staff, reviewed the home's documentation of the complaint logs and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Resident Charges

Skin and Wound Care

Sufficient Staffing

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 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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
(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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. 6(1)(c) The plan of care for two residents does not set out clear directions to staff and others who provide direct care to them.

1. The physician ordered an identified resident a specific treatment, however staff stated the resident often refuses the treatment, yet there was no direction in the plan of care to manage the refusals.

2. Nursing staff state the identified resident often refuses care, including showers and tub baths. The documentation on the flow sheets confirmed the resident often refuses bathing. The plan of care does not direct staff, how to meet the resident's hygiene needs when they refuse care.

3. The plan of care stated the resident uses their own wheelchair to sit in, however the resident was observed in an alternate chair. Interview with the Registered Nurse revealed the nursing staff requested another chair be provided due to poor seating. The maintenance department provided one from the storage area, however it did not meet the resident's needs. The Personal Support Workers were not clear which chair the resident should be using.

4. The plan of care for an identified resident not identify the resident had an open area. The resident started treatment, however the plan of care was updated approximately one month after the open area occurred. The plan of care did not set out clear directions to staff regarding the care required to manage the open area. The physician provided orders related to the treatment and they were not identified in the plan of care.

5. An identified resident's plan of care does not reflect the change in seating directive. The RN verbally directed staff to put an identified resident in a specific wheelchair. The plan of care did not reflect what type of chair the resident was to sit in, for how often and directions regarding the seat belt. The resident was observed in a reclining chair however foot rests were not applied and their head was not supported as it was placed in a 45 degree reclined position. The plan of care does not reflect the resident does not want to be in a reclined position. The resident was observed to be in one for 3 hours. Interviews with Personal Support Workers confirm they were unaware of which chair the resident was to sit in and in what position, nor whether the seat belt should be on or off.

6. An identified resident has received one shower and refused one shower during one month in 2011. They received two showers and refused one in another month in 2011. The resident has not received a shower during another month in 2011 and there is no documentation of their refusals or clear direction to staff on how to manage the refusal of care. The documentation in the progress notes states the resident often refuses care, however the plan of care does not provided clear directions to staff and others who provide direct care to the resident of what to do when they refuse or how direct care staff are to meet the resident's hygiene needs.

2. 6(7) The care set out in the plan of care for a resident was not provided.
The plan of care directed staff not to tilt the resident's wheelchair, however the resident was observed in a reclined position.

3. 6(10)(c) 1. An identified resident's plan of care was not reviewed and revised when the interventions in her plan were not effective in managing their pain. The identified resident was receiving interventions to manage their pain, as per the plan of care, however the resident had verbalized to staff the interventions were not effective and expressed having an increased level of pain. The identified resident did not receive a re-assessment or revision to their plan of care.

2. An identified resident was not reassessed and their plan of care reviewed when the care set out in the plan was not effective. The identified resident was assessed to sit in their own wheelchair when they were out of bed, however the resident was seated in a chair borrowed from the home.
A seat belt was observed secured around the resident's abdomen and inaccessible to the resident. The identified resident's seating was not reassessed and their plan of care revised when the seating identified in their plan of care was not effective seating.

4. 6(5) The substitute decision maker for an identified resident was not given an opportunity to participate fully in the development and implementation of the plan of care. The plan of care directed staff to use the resident's wheelchair daily to sit in, however when the resident began to lean in their wheelchair, staff decided to change their seating and put

the resident into a chair borrowed from the basement. The substitute decision maker was not given an opportunity to participate in the implementation of the plan of care.

5. 6(11)(b) An identified resident's plan of care was not reviewed and revised when the pain management strategies were ineffective, or different approaches were considered in the revision of the plan of care. The clinical record revealed medication for pain control was provided, however it was discontinued due to an adverse reaction. This reaction was not identified in the plan of care or was there any evidence an alternative approach was considered to manage their pain.

6. 6(4)(a) The licensee did not ensure staff and others involved in the different aspects of care of an identified resident collaborate with each other 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. According to the clinical record, nursing staff have not completed a pain assessment to manage the resident's pain. The Occupational Therapist has not assessed the resident's seating to improve their comfort. Staff have not collaborated with each other to develop a plan of care to manage the resident's comfort.

In 2011 the inspector observed an identified resident in a tilt wheelchair with a back facing restraint on and positioned in a reclined 45 degree angle. Nursing and physiotherapy did not collaborate with each other. There are multiple issues related to the residents seating: comfort, independent mobility, head support, tilting needs, communication with the family. None of these issues have been assessed by any discipline. The resident was observed in bed, however staff do not know which chair to put the resident in if they got the resident up. The plan of care does not include integrated and consistent assessments from all staff involved in the 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 that ensures: clear directions are provided to staff and others who provide direct care to the resident, assessments of each resident is integrated and consistent with and compliment each other, each resident and/or substitute decision maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, care set out in the plan of care is provided to the resident as specified in the plan, the care in the plan of care is evaluated and the resident is reassessed and the plan of care reviewed and revised when necessary including consideration of different approaches in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 subsections:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
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.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. 31(2)5 The plan of care did not include consent by the substitute decision maker for the restraint. The plan of care identified a seat-belt is used, however the resident is unable to undo the restraint by themselves. The seat-belt was observed inaccessible to the resident and was noted to be at the side of wheelchair. There was not a consent in the plan of care for the use of the seat-belt.

2. 31(2)4 The restraint plan of care for the same resident did not include an order by the physician to apply it. The identified resident was observed wearing a seat-belt which was inaccessible to them, thus not allowing the resident to undo it by themselves, as described in the the plan of care. The plan of care did not include an order by the physician.
3. 31(1) The plan of care for an identified resident states the resident was to wear a front closing seat-belt, which they could undo independently. The identified resident was observed wearing a rear facing seat belt. Staff confirmed the resident should not have a seat-belt applied that does up at the rear. The resident's plan of care did not include the use of a rear facing wheelchair restraint.

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 that ensures resident's are not restrained by a physical device if restraining of the resident is not included in their plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. 110(2)5 Staff do not release an identified resident's seat-belt restraint and reposition the resident. Observation over a three hour period confirmed the staff are not repositioning the resident in their wheelchair. Interview with Personal Support Workers confirmed this resident is not re-positioned.
2. 110(2)1 Staff applied a physical device without instructions specified by the physician or registered nurse in the extended class. An identified resident was observed wearing a rear facing seat belt and their wheelchair was tilted in a 45 degree recline position from 1200-1600 hours. There was no physicians order to apply the physical restraint or to recline the resident.

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 that ensures staff apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care
Specifically failed to comply with the following subsections:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. 25(2) An identified resident had their fingernails trimmed,however fingernail care was not been provided. In August, 2011 the identified resident was observed with fingernails trimmed, however black debris was observed under all fingernails. The identified resident requires total care for all aspects of bathing, therefore is dependent on staff to provide nail 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 that ensures each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Staff did not use a safe transferring technique while assisting an identified resident. The identified resident was being moved to another location of the building and sustained an injury. Staff did not transfer the resident safely resulting in injury.

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 that ensures all staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference
Specifically failed to comply with the following subsections:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. 27(1)(a)An identified resident has not been provided with an interdisciplinary team care conference within six weeks following the resident's admission to discuss the plan of care and any other matters of importance to the resident and her substitute decision maker. The nursing staff identified the administrative office manages the schedule for care conferences. The nursing office and the substitute decision maker has confirmed the admission conference has not occurred.

Issued on this 30th day of November, 2011

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