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

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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
Jun 7, 2013	2013_105130_0012	H-000184-13	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

GILLIAN TRACEY (130)

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): May 13, 14 and 15, 2013

During the course of the inspection, the inspector(s) spoke with The Administrator, Assistant Administrator, Director of Care, RAI Coordinator, Registered Staff, Physiotherapy Assistant, personal support workers, BSO (Behavioural Support Outreach) Staff and residents.

During the course of the inspection, the inspector(s) Interviewed staff, reviewed clinical records and policies and procedures, interviewed residents and observed resident care related to H-000184-13.

The following Inspection Protocols were used during this inspection:
Pain

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident was properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

(a) In 2013, Resident #001 sustained a fall resulting in an injury. Following the fall the clinical record showed the resident exhibited responsive behaviours, refused to ambulate or participate in physiotherapy. The resident was not formally assessed until a request was made in 2013. The resident was transferred to the hospital the same day, where the resident was confirmed to have a fracture. The resident had an undiagnosed fracture for 16 days.

(b) According to the plan of care, Resident #005 had ongoing issues with pain management. Progress notes recorded by the physician over a two month period in 2013, indicated the resident's pain was not being controlled, which prompted changes to analgesic orders. The resident did not have a formal pain assessment completed by nursing staff for at least two months despite numerous changes to analgesics and expressions of pain.

(c) Residents #001 and #005 were not cared for in a manner consistent with their needs. [s. 3. (1) 4.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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).

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 did not ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent and complemented each other.

(a) Progress notes reviewed for Resident #004, in 2013, indicated the resident was experiencing pain; however, a pain assessment completed by nursing staff during the same time period in 2013, indicated the resident was not experiencing pain. The resident's pain was scored "low" on a pain assessment.

(b) According to the clinical record, Resident #003 was assessed by the physician five times during an identified time period in 2013. The physician documented the resident's complaints of increased pain on each assessed visit and as a result, adjusted the resident's analgesics; the resident's pain was scored "low" on a pain assessment.

(c) Assessments for these residents were not integrated, consistent and did not complement each other. [s. 6. (4) (a)]

2. The licensee did not ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

(a) The plan of care for Resident #001 was reviewed in 2013. The resident sustained a fall in 2013. Progress notes recorded in 2013, indicated the resident was at risk for falls and required specific interventions put in place; however, the plan of care that provided direction to front line staff did not include any of these noted interventions. X-rays taken in hospital in 2013, confirmed the resident had a fracture. The care plan indicated staff were to provide specific hygiene and grooming assistance following the identification of the fracture; however, progress notes and staff confirmed that in 2013, the resident returned from the orthopaedic clinic with a change in directions for staff regarding hygiene and grooming needs. Staff confirmed the plan was not updated when the resident's status had changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that, (b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee did not ensure that each resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote or manage bowel and bladder continence based on the assessment and that the plan was implemented.

(a) According to the plan, Resident #001 was incontinent, wore a brief and required two staff to provide total assistance with toileting before and after meals and every evening. In 2013, the resident was observed from 1030 to 1400 hours and was not provided assistance with toileting during this time period. Staff interviewed confirmed the resident was toileted before breakfast service at 0800 hours and had not been toileted since that time.

(b) The plan of care for Resident #2 indicated the resident required total assistance of two staff to toilet before and after meals and every evening. The resident was observed on May 14, 2013, from 1030 to 1400 hours. The resident did not receive assistance with toileting before lunch. Staff interviewed confirmed that the resident should have been toileted between the hours of 1030 and 1400 hours.

(c) These residents did not receive care in accordance with their individualized continence care plans. [s. 51. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that any plan, policy, protocol, procedure, strategy or system was complied with. The home's policy identified as Pain Management 05-01-04A, dated January 2013, indicated that "Two Pain Assessment Tools" were available to be used: "Pain Assessment Tool for Cognitively Alert Resident" and "Pain Assessment Tool for Cognitively Impaired or Non-communicative Resident". The policy indicated that assessments were to be completed on admission (within 72 hours), quarterly if last assessment indicated pain (timed to coincide with quarterly updates), annually if last assessment did not indicate pain (timed to coincide with annual interdisciplinary conference) and "prn" when resident complained of pain.

(a) Resident #001 was admitted to the home in 2013, and did not have a pain assessment completed following admission. Documentation indicated the resident had ongoing recorded responsive behaviours following admission and after a recorded fall in 2013. According to documentation the resident was resistive to care and refused range of motion exercises and walking with physiotherapy. In 2013, it was reported that the resident was in pain and a request was made to transfer the resident to hospital for an assessment. The hospital confirmed the resident had a fracture. The resident returned to the home a day later, with interventions in place to manage the injury. Documentation and staff interviewed confirmed a pain assessment was not completed until some time later in 2013. The Director of Care was interviewed and confirmed the resident should have been assessed upon admission, following the recorded fall, when responsive behaviours escalated and upon return from hospital, but did not have a pain assessment completed for 74 days after sustaining the fall.

(b) Resident #003 was assessed by the physician on five occasions during an identified time period in 2013. The physician documented the resident's complaints of increased pain on each assessed visit and ordered changes to analgesics. A pain assessment was not completed by nursing staff until some time later in 2013.

(c) According to the progress notes, Resident #4 was experiencing pain on at least three occasions during an identified time period in 2013. A pain assessment was not completed until some time later in 2013. This information was verified by staff. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system was complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of pain, related to the following:

(a) In 2013, Resident #001 sustained a fall with a minor injury. According to the record the resident had no apparent injury resulting from the fall, but staff would continue to monitor the resident. The clinical record showed the resident was resistive to care and exhibited responsive behaviours in excess of eight times during an identified time period in 2013, at which time the resident was sent to hospital for assessment of pain. X-rays confirmed the resident had a fracture. A pain assessment was not completed following the fall, despite ongoing responsive behaviours and resistiveness to care, nor upon return from hospital with a known fracture. The plan of care for Resident #4 identified that the resident had ongoing issues with pain management. On a number of identified dates in 2013, staff documented that the resident continued to express pain.

(b) According to the plan of care Resident #5 had ongoing issues with pain management. Progress notes recorded by the physician during an identified time period in 2013, indicated the resident's pain was not being controlled, which prompted changes to analgesic orders. The resident did not have a formal pain assessment completed by nursing staff until some time later in 2013. [s. 26. (3) 10.]

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 plans of care for every resident is based on, at a minimum, interdisciplinary assessment of pain, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that any resident who was dependent on staff for repositioning was repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load.

(a) The plan of care for Resident #001 indicated the resident was to be repositioned and receive skin care every two hours. On an identified date in 2013, the resident was observed and not repositioned for a period in excess of five hours. This information was confirmed by staff. [s. 50. (2) (d)]

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 any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required., to be implemented voluntarily.

Issued on this 11th day of June, 2013

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

Gillian Tracey