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 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
Oct 11, 2018	2018_739694_0014	015264-18	Complaint

Licensee/Titulaire de permis

Steeves & Rozema Enterprises Limited
265 North Front Street Suite 200 SARNIA ON N7T 7X1

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

Lanark Heights Long Term Care Centre
46 Lanark Crescent KITCHENER ON N2N 2Z8

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

AMANDA COULTER (694)

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): August 20, 21, 22, 23, 24 30, 31 and September 4, 2018.

Complaint log #015264-18 related to Prevention of Abuse and Neglect, Continence Care and menu planning. This inspection was completed in conjunction with Critical Incident inspection 2018_739694_0013.

During the course of the inspection, the inspector(s) spoke with Administrator, Manager of Resident Care (MOC), Assistant Managers of Care (AMOC), the Life Enrichment Manager, Food Services Manager, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker, Life Enrichment Worker and residents.

During the course of the inspection, the inspectors toured the facility, reviewed resident clinical records, reviewed the facility's policies, annual evaluation of program reviews and training records and residents care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Food Quality
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. (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 written plan of care for each resident is reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A) Resident #001 was admitted to the home in June 2018. Resident #001 continence was assessed on admission. A clinical record review was completed and documentation in the progress notes of resident #001 stated they attended a specialist appointment on a certain date in July 2018 and returned to the home with a device in place.

In an interview with staff #115, they stated that there was treatment records and a task item on Point of Care (POC) for Personal Support Worker (PSW) documentation, however it was not noted on the resident’s written care plan. Resident #001 had a device during this time.

B) Resident #002 was admitted to the home on a specific date in October 2013. On a certain day in September 2017, resident #002 had a fall and sustained an injury. There was a significant change after this incident affecting the resident's activities of daily living (ADLs). In an interview with Staff #115 acknowledged that resident #002 returned to the facility after a medical procedure. The written plan of care was not revised and changed to reflect the resident's care needs. Staff did not have clear direction of the resident’s care needs regarding continence care.

In an interview with staff #116, they stated it is an expectation when a resident had a significant change affecting their continence, the program lead or Registered Nurse (RN) would initiate and review any changes, then once a month at a continence meeting, any care plans would be updated.

Review of the home’s continence care program policies titled “RCM 10-01-02 Continence Care and Bowel Management Program”, last revision on October 24, 2017. Staff were directed to promote dignity and comfort, and maximize independence to enhance resident’s quality of life.

The licensee failed to ensure that resident #001 and resident #002 written plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

This area of non-compliance was identified during a Complaint inspection, log #015264-18. [s. 6. (10) (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 the written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

A) Resident #001 was admitted to the home on a certain day in June 2018. Resident #001's continence was assessed at the time of admission.

The written care plan was updated on a certain day in August 2018 and bowel

continence was revised. Staff #115 confirmed there were no continence assessments completed when resident #001 had a significant decline in bowel continence, as a result of a specific medical diagnosis. Staff #115 was reviewing resident’s progress notes and explained to Long Term Care Home (LTCH) inspector that the resident attended an external appointment on a certain day in July 2018 and returned to the home with a device. Staff #115 confirmed there was no continence assessment tool used at the time of change in the resident’s continence.

B) Resident #002 was admitted to the home on a certain day in October 2013.

On a certain day in September 2017 resident #002 had a fall and they sustained an injury. There was a significant change after this incident affecting the resident's activities of daily living (ADLs). In an interview with Staff #115 they acknowledged that resident returned to the facility after a medical procedure on a certain day in September 2017. The written plan of care was not revised until the following month and changed to reflect the resident's care needs. Staff did not have clear direction of the resident’s care needs regarding continence care.

In an interview with staff #115 they stated a change in a resident's continence would trigger on the MDS assessment, the continence assessment would then be completed by registered staff. Staff #115 acknowledged there were no continence assessments completed at the time of resident #001 and #002 each had an injury that caused a change in their continence. The residents were not reassessed using an instrument specific for continence. Minimum Data Set (MDS) assessments also did not reflect any change in the resident #001 and #002's continence.

Review of the home’s continence care program policies titled “RCM 10-01-02 Continence Care and Bowel Management Program”, last revision on October 24, 2017. Staff were directed to complete Continence Assessments, using a clinically appropriate assessment instrument upon admission, with any decline of a resident’s bowel or bladder function/continence level indicated by the quarterly MDS; or with any decline of a residents bowel or bladder continence level.

The licensee failed to ensure that resident #001 and #002 received an assessment that was conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence when their needs changed.

This area of non-compliance was identified during a Complaint inspection, log #015264-

18. [s. 51. (2) (a)]

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 each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, to be implemented voluntarily.

Issued on this 6th day of November, 2018

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

Original report signed by the inspector.