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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
Janaury 7 and 10, 2011	2011_192_2678_10Jan094621 2011_192_2678_10Jan101827 2011_192_2678_10Jan112039	Critical Incident H – 00141 H – 02361, H – 02248 H – 02136, H – 02139, H-01903

Licensee/Titulaire
Revera Long Term Care Inc., 55 Standish Court, 8th Floor, Mississauga, Ontario, L5R 4B2

Long-Term Care Home/Foyer de soins de longue durée
Brierwood Garden's Long Term Care, 425 Park Road North, Brantford, Ontario, N3R 7G5

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville, Nursing Inspector #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection and complaint inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

During the course of the inspection, the inspector: Reviewed medical records, policy and procedure, observed care provided to the residents and the home environment.

The following Inspection Protocols were used during this inspection: Prevention of Abuse, Neglect and Retaliation, Skin and Wound Care, Falls Prevention and Infection Prevention and Control Inspection Protocols.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
1 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 23(1)(a)(i)(ii)and(iii)

Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

i)abuse of a resident by anyone,
ii) neglect of a resident by the licensee or staff, or
iii)anything else provided for in the regulations;

Findings:

A progress note indicates that a specific resident's power of attorney complained to a registered staff member that a resident had received inappropriate care. The staff member documenting the incident acted as a representative of the licensee in accepting the information and according to the abuse policy should have reported the concern to the Administrator. During interview, the Administrator and director of Care denied knowledge of this concern. No investigation was conducted or report of abuse/neglect was filed with the MOH related to this incident.

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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, ensuring that all staff are aware of legislated requirements related to the reporting of actual, suspected or witnessed abuse, neglect or retaliation toward a resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 23(2)

A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b).

Findings:

A critical incident was completed by the licensee that indicated a resident had sustained a bruise as a result of an interaction with a staff member. The results of the investigation into this incident were not reported to the Director.

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WN #3: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

The plan of care for a specific resident does not provide clear direction to staff.

i) Under risk for falls in the plan of care for a specified resident interventions identified are very vague, are not resident specific and do not provide specific interventions for the prevention of falls.

ii) A note in the resident's interdisciplinary progress note indicates that a bed alarm was put into place - this is not documented in the plan of care.

The plan of care for a specific resident does not provide clear direction to staff.

i) The progress notes for a specified resident indicates a device.
The plan of care indicates that the resident is to be toileted every 2 hours, uses an incontinence product and that the health care team is to support and offer voiding/elimination opportunities based on the resident's schedule. There is no indication of the use of the device within the plan of care. Care of the device is not included in the plan of care.

Resident's identified as requiring wound care by a review of the Treatment Record do not have a plan of care that provides clear direction to staff.

i) The type of wound, location of the wound, and treatment being provided is not always clearly identified in the plan of care.
A specified resident is identified in the plan of care as having an ulcer, no location is specified. Interventions within the plan of care relate only to the use of dietary supplements. There are notations in the progress notes of the location of wounds.

ii) Specific information such as whether a resident uses any pressure relieving devices e.g. a therapeutic surface, is not identified in the plan of care. Positioning needs and pressure relief are not addressed.

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WN #4: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(4)(a)

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;

Findings:	
There is evidence that the team members do not collaborate with each other so that assessments are integrated and consistent related to wound and skin care. i) Registered staff are responsible for the completion of wound and skin assessments for the Residents of the home. The Wound Care Champion is responsible for documenting on the Plan of Care. There is no consideration of the residents need for pain relief, related to wounds or wound Care.	
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WN #5: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, O. Reg. 79/10, s. 8(1)(b)	
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 all applicable requirements under the Act; and (b) is complied with.	
Findings: i) The falls program for the home indicates on the post fall algorithm that the plan of care is to be reviewed and that for all residents having sustained a fall - the fall status automatically changes to high and falling star program is implemented. The Falling Star Program has not yet been implemented in this home. No change in risk status was triggered, or identified on the plan of care, even though a specified Resident sustained 4 falls in 3 days. ii) The Post Fall Documentation algorithm - part of the Fall Interventions Risk Management (FIRM) Program, indicates that the plan of care is to be revised to include additional goals and interventions. This did not occur for the specified resident.	
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WN #6: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, O. Reg. 79/10, s. 49(2)	
Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.	
Findings: A specified resident sustained 4 falls in 3 days. There is no evidence of post fall assessments having been completed for the resident. The resident's condition was changing as evidenced by the increase in falls, decreased appetite, fever, nausea and emesis; a comprehensive assessment and implementation of appropriate intervention to prevent further falls was not completed.	
Inspector ID #:	Nursing Inspector #192

<table>
<tr><td>Signature of Licensee or Representative of Licensee
Signature du Titulaire du représentant désigné</td><td>Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.

4 Wurk for D Savelle - Sept 29/11
Revised for the purpose of publication</td></tr>
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