Ontario

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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jul 16, 17, 18, Aug 8, Sep 10, Oct 14, 2012	2012_070141_0013	Complaint

Licensee/Titulaire de permis

HOLLAND CHRISTIAN HOMES INC
7900 MCLAUGHLIN ROAD SOUTH, BRAMPTON, ON, L6Y-5A7

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

GRACE MANOR
45 Kingknoll Drive, BRAMPTON, ON, L6Y-5P2

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

SHARLEE MCNALLY (141)

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 the Administrator, the Director of Care (DOC), the Assistant Director of Nursing (ADOC), the Resident Assessment Instrument Minimum Data Set (RAI MDS) coordinator, registered nurses (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) reviewed resident records, home's policies and procedures related to skin care, pain, and documentation, observed residents.

Log# H-000047-12

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Pain

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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).

Findings/Faits saillants :

1. The licensee did not ensure that residents were reassessed and their plans of care reviewed and revised at least every 6 months.
a) An identified resident developed a pressure ulcerin November 2011. The resident commenced on pain medication as required at this time and received multiple doses of the medication through December 2011. The MDS assessment for December 2011 identified the resident as having daily moderate pain due to soft tissue injury. A Resident Assessment Protocol (RAP) was not completed at this time. The resident received multiple administrations of pain medication in January 2012. The resident's plan of care dated October, 2011 and January, 2012 did not identify the resident as at risk for pain and did not include strategies to minimize the pain. The MDS coordinator confirmed that she was responsible for completion of all RAPS in the home and did not complete RAPS for pain. The DOC confirmed that the home had stopped completing quarterly RAPS related to resident pain. s.6(10)(b)
b) An identified resident was identified in their plan of care as having pain. The MDS assessment completed in April and July, 2012 identified the resident's pain as moderate and occurring less than daily. The resident had a physician order for narcotic pain medication as needed for breakthrough pain. The resident received the medication multiple times in May, June, and July, 2012. The resident did not have a RAP completed related to pain for April or July 2012. s.6(10)(b)
c) An identified resident had a pressure ulcer. The plan of care identified the resident was at risk of pain but did not identify risk of pain from the skin breakdown. The quarterly MDS assessment for May 2012 identified the resident as having pain. In May 2012 the resident received a physician order for narcotic pain medication as needed for severe pain and prior to dressing change. The resident did not have a RAP completed related to pain in May, 2012 when the most current RAPs were completed. s.6(10)(b)
2. The licensee did not ensure that an identified resident's plan of care was reviewed and revised when the care set out in the plan was no longer necessary. The resident was receiving an identified treatment for skin breakdown. The treatment was discontinued by the physician in July, 2012 but the plan of care identified the treatment as an ongoing strategy. 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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(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 a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears and wounds, was assessed at least weekly by a member of the registered nursing staff, if clinically indicated. An identified resident was observed by a registered nursing staff in November, 2011 to have skin breakdown. A dressing was applied and documentation was completed in the resident's progress notes and the Nursing Daily Report. Twelve days later the wound was described as deteriorated and the resident was commenced on medication to treat. There was no documentation in the resident's progress notes or in the pain assessment tool to indicate a weekly skin assessment had been completed during the twelve days. The DOC confirmed that weekly skin assessments for this resident had not been completed during this time period. s.50(2)(b)(iv)

Issued on this 18th day of October, 2012

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