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**
**Direction de l'amélioration de la performance et de la conformité**

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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 |
|---|---|---|
| May 5, 11, 13, Oct 31, Nov 1, 2011 | 2011_027192_0017 | Complaint |

**Licensee/Titulaire de permis**

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street, St. Catharines, ON, L2N-4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street, St. Catharines, ON, L2N-4J4

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

DEBORA SAVILLE (192)

## 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 residents, family, the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, and Personal Support Workers related to H-000845-11.**

**During the course of the inspection, the inspector(s) reviewed medical records and policy and procedure.**

**The following Inspection Protocols were used during this inspection:**

**Dignity, Choice and Privacy**

**Nutrition and Hydration**

**Pain**

**Personal Support Services**

**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (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).**

**Findings/Faits saillants :**

1. Care set out in the plan of care was not provided as specified in the plan.
A specified resident's plan of care indicates that there is to be one person physical assistance, extensive assistance for all meals. Discussion with the Director of Care confirms that the specified resident was left unattended at meal time, an incident occurred causing harm to the resident.
2. The plan of care was not reviewed and revised when care needs changed.
a) A specified resident sustained an injury. The plan of care was not updated as of May 5, 2011 to include this change in condition, treatments required, or changes in daily care required related to this change in condition.
b) The injury site was investigated for infection. The results were received by the home and called to the physician. Treatment for infection was initiated. The plan of care was not revised to include clear direction for staff related to this change in condition.
c) A specified resident sustained an injury that resulted in pain. The plan of care reviewed on May 5, 2011 was not revised to include information related to pain.
d) A specified resident was hospitalized. The plan of care was not revised to include new diagnosis on her return from hospital.
e) The plan of care for a specified resident, indicates that the resident is at risk of urinary tract infections and that staff should encourage fluid intake at meals and snacks and push fluids when signs and symptoms of urinary tract infection are present. The progress notes for the specified resident indicated that a Personal Support Worker (PSW) reported the resident's urine as being foul smelling, a symptom of infection or dehydration. No further assessment of the resident was completed, even though the resident was noted to have an increase in lethargy, vomiting, refusal of meals and medications and complaints of lower right quadrant pain that exacerbated over the course of the next 10 days. The resident was admitted to hospital.
3. The plan of care for a specified resident does not provide clear direction to staff.
a) The resident sustained an injury. The staff member involved in the incident was re-instructed, but the care needs of the resident were not added to the plan of care to provide clear directions to staff.

***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 the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident; that care is provided to the resident as specified in the plan of care; and the resident is reassessed and the plan of care reviewed and revised when the residents care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care**

**Specifically failed to comply with the following subsections:**

**s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:**
**1. Customary routines.**
**2. Cognition ability.**
**3. Communication abilities, including hearing and language.**
**4. Vision.**
**5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.**
**6. Psychological well-being.**
**7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.**
**8. Continence, including bladder and bowel elimination.**
**9. Disease diagnosis.**
**10. Health conditions, including allergies, pain, risk of falls and other special needs.**
**11. Seasonal risk relating to hot weather.**
**12. Dental and oral status, including oral hygiene.**
**13. Nutritional status, including height, weight and any risks relating to nutrition care.**
**14. Hydration status and any risks relating to hydration.**
**15. Skin condition, including altered skin integrity and foot conditions.**
**16. Activity patterns and pursuits.**
**17. Drugs and treatments.**
**18. Special treatments and interventions.**
**19. Safety risks.**
**20. Nausea and vomiting.**
**21. Sleep patterns and preferences.**
**22. Cultural, spiritual and religious preferences and age-related needs and preferences.**
**23. Potential for discharge. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The plan of care for a specified resident is not based on interdisciplinary assessment of pain and other special needs. The specified resident was hospitalized for changes in condition including nausea, vomiting and pain. The resident received specified treatments in hospital and returned to the home. The specified resident sustained an injury causing pain as documented in the progress notes.
The plan of care for the specified resident does not include an assessment of this residents pain related to the identified changes in her condition.

2. A specified resident sustained an injury. The plan of care was updated and included that the specified resident required Extensive Assistance - one person physical assist for eating. There was no further update or clarification following the incident that resulted in injury to the specified 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 ensuring that the plan of care for each resident of the home includes, but is not limited to health conditions, including allergies, pain, risk of falls and other special needs and special treatments and interventions, to be implemented voluntarily.***

**WN #3: 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. A specified resident sustained an injury. There is no evidence of 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. A review of the documentation for the specified resident was completed - no wound assessment is recorded on the Treatment Administration Record when the incident occurred. No assessments were conducted for an 11 day period following the incident.

A specified resident was prescribed treatment for changes in skin integrity. The Treatment Administration Record (TAR) for the resident indicates that the treatment was completed - no weekly assessment of the effectiveness of the treatment is recorded on the back of the TAR or in the progress notes.

Discussion with the Registered Practical Nurse working evenings on May 5, 2011 determined that registered staff don't do wound assessments at Heidehof. Discussion with the Director of Resident Care determined that wound assessments are to be completed by registered staff on the back of the TAR.

***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 a resident exhibiting altered skin integrity is assessed using a clinically appropriate assessment instrument and at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.***

**Issued on this 4th day of November, 2011**

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