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 |
|---|---|---|
| Oct 17, 18, 19, 22, 23, 24, 2012 | 2012_179103_0006 | Complaint |

**Licensee/Titulaire de permis**

BELCREST NURSING HOMES LIMITED
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

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

BELCREST NURSING HOMES LIMITED
250 Bridge Street West, BELLEVILLE, ON, K8P-5N3

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

DARLENE MURPHY (103)

## 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 Registered Practical Nurses, a Registered Nurse, the Director of Care and the Administrator.**

**During the course of the inspection, the inspector(s) did a walkthrough of the home, reviewed resident health care records including medication administration records, plans of care, progress notes and hospital discharge documentation, fall assessment tools and pain assessment tools. The log number for this inspection is O-001769-12.**

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

**Falls Prevention**

**Pain**

**Personal Support Services**

**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. (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 has failed to comply with LTCHA, 2007 s. 6 (10) (b) whereby the resident's plan of care was not reassessed when a resident had a change in care needs.

Resident #1 was cognitively impaired and according to the plan of care, had severely impaired decision making skills. On an identified date, Resident #1 was found on the floor and was complaining of lumbar pain.

An identified time period was reviewed, and Resident #1 was documented as having the following changes in behavior:
-awake during the night
-demonstrated an increase in agitation and refusal of care
-had a decline in appetite and
-had increased unsteadiness on his/her feet, requiring 2 staff for all transfers

Throughout this time period, there was no evidence that the resident received a reassessment for the documented changes in care needs.

On another identified date, Resident #1 sustained another fall.

An identified time frame was reviewed, the resident demonstrated the following behaviors:
-2 person transfers were difficult
-unable to weight bear at times; Sara lift required
-increased restlessness
-resident was found crying
-combative with staff during care
-lump was found on the mid chest area

On an identified date, a registered staff member reassessed Resident #1's physical condition. The physician was notified and agreeable to hospital transfer to determine the presence of any possible injuries.

Resident #1 was admitted to hospital and required surgical intervention. Resident #1 subsequently died.

***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 residents that demonstrate a change in care needs are reassessed, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

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

**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. O. Reg. 79/10, s. 49 (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 49 (2) whereby a resident that had fallen did not receive a post fall assessment.

On an identified date, Resident #1 was found sitting on the floor in the hall. Staff failed to complete a post fall assessment despite the resident complaints of pain and the presence of swelling in the affected area. The resident was sent to hospital the following day and was diagnosed with a fracture.

On another identified date, Resident #1 was found sitting on the bathroom floor and stated they had hit their head. Staff initiated head injury routine, but failed to complete a post fall assessment to rule out any physical injuries resulting from the fall.

The Director of Care was interviewed and advised the home has developed a post fall assessment decision tree and a post fall action plan to ensure post fall assessments are completed and consistent.

***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 residents that have fallen receive a post fall assessment, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

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

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 52 (2) whereby a resident with ongoing complaints of pain was not assessed using a clinically appropriate assessment instrument.

Resident #1 was cognitively impaired and assessed as having severely impaired decision making skills. On an identified date, the resident sustained a fall and complained of lumbar pain. The resident's progress notes and medication administration records were reviewed for an identified period of time. The resident continued to complain of sore back/legs/generalized pain throughout the identified period of time and Acetaminophen was administered on eighteen occasions during this time.

There was no documented evidence of pain assessments for Resident #1's ongoing complaints of pain.

The Director of Care was interviewed and advised the home was not utilizing a pain assessment tool designed for resident's with cognitive impairments at that time. The home is now conducting pain assessments using the Abbey Pain Scale which is designed to assess pain in resident's with dementia or those who are unable to verbalize pain.

***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 residents with ongoing complaints of pain are assessed using a clinically appropriate assessment instrument, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care**

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

**s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,**
**(a) mouth care in the morning and evening, including the cleaning of dentures;**
**(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and**
**(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 34 (1) (a) whereby a resident did not receive mouth care in the morning and evening.

Resident #1 had been assessed to require staff assistance for mouth care. The Personal support worker flow sheets were reviewed for the month of June 2012. According to the flow sheets, Resident #1 did not receive mouth care in the morning and evening on twelve out of thirty days. Seven of the thirty days had incomplete documentation.

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with O. Reg 79/10 s. 30 (2) whereby routine foot care provided to residents is not documented.

S100 was interviewed and is responsible for providing advanced foot care to diabetic residents. S100 advised all residents receiving advanced foot care have a treatment record that is completed after each episode of foot care. S100 advised Resident #1 was assessed, did not require advanced foot care, and would have received routine foot care from the Personal support workers (PSW).

Personal support workers S101 and S102 were interviewed in regards to foot care. Both staff members advised routine foot care is to be provided by the bath team staff at bath time to all residents not requiring advanced foot care. Both staff members stated there is no place to chart routine foot care on the Personal support worker flow sheets and were unable to say how foot care is reflected in the documentation.

The flow sheets for Resident #1 was reviewed and there is no documentation to reflect the foot care the resident received.

**Issued on this 24th day of October, 2012**

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