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
Feb 16, Mar 20, 21, 22, 27, 28, 29, 30, 2012	2012_138151_0005	Complaint

Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF PARRY SOUND WEST
21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2

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

BELVEDERE HEIGHTS
21 BELVEDERE AVENUE, PARRY SOUND, ON, P2A-2A2

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

MONIQUE BERGER (151)

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 Administrator/CEO, Director of Care, Assistant Director of Care, Registered Staff, Personal Support Workers (PSW), residents

During the course of the inspection, the inspector(s)
- made direct observations of the delivery of care and services to residents.
- did daily environmental walk-through of the home
- reviewed resident health care records
- reviewed policies and procedures manuals,
- reviewed the home's programs in regards to the management of responsive behaviours
- reviewed the homes quality assurance program in reference to lift slings,
- conducted an audit of home's lift slings,

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (4) 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; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. ***Staff interviews confirms that a resident was experiencing a change in health status. Staff interviewed confirmed that they communicated their concerns to the Registered Staff on duty on those shifts. Inspector reviewed the resident's health care records and the unit's end of shift reports and found no entries, firstly, in acknowledgment of staff to staff communication of the concerns, and, secondly, that registered staff had assessed the resident's changing condition.

Evening shift progress notes are confusing in establishing the time line in regards of PSW notification of a request for Registered Staff to assess the resident.

The licensee has not ensured that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change. [LTCA,2007 S.O.2007,c.8, s.6 (10) (b)]

2. ****Staff interviews confirm that a resident was experiencing a change in her health status. Staff interviewed confirmed that they communicated their concerns to the Registered Staff on duty on those shifts. Inspector reviewed the resident's health care records and the unit's end of shift reports and found no entries, firstly, in acknowledgment of staff to staff communication of the concerns, and, secondly, that registered staff had assessed the resident's changing condition.

The licensee has not ensured that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.
[LTCA,2007 S.O.2007,c.8, s.6.(4) (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 the staff and others who provide direct care to a resident collaborate with each other in the assessment and re-assessment of the resident so that their assessments are integrated and consistent with and compliment one another and that the plan of care is reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: 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. **** Staff interviews confirmed that a resident was experiencing a change in health status on the night and subsequent day shift. Staff interviewed confirmed that they communicated their concerns to the Registered Staff on duty on those shifts. Inspector reviewed the resident's health care records and the unit's end of shift reports and found no entries, firstly, in acknowledgment of staff to staff communication of the concerns, and, secondly, that registered staff had assessed the resident's changing condition.

Inspector reviewed the evening shift progress notes and found them to be confusing in establishing the time line of events. Three notes are found, each having a different time for when the PSW Staff notified Registered Staff with a request to assess the resident. Two of these notes, by the same staff person, are made as "late entries" and occur 6 hours after the resident's demise. The first of these "late entry" notations states "vital signs taken". No values are entered for the vital signs taken.

In summary:
- no documented registered staff assessment found for 2 (two) shifts in response to PSW advisement of resident's worsening condition,
- no notations on the end-of-shift reports for 2 (two) shift in advisement to on-coming staff of resident's declining health status,
- no documented vitals signs recorded as having been taken,
- late entry documentation with confusing "approximate" time of actual occurrences.

The licensee has not ensured 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)]

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 any action taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The following occurrences demonstrate a pattern of inaction that jeopardized the well-being of a resident.

* Staff interviews confirmed that a resident was experiencing a change in health status on the night and subsequent day shift. Staff interviewed confirmed that they communicated their concerns to the Registered Staff on duty on those shifts. Inspector reviewed the resident's health care records and the unit's end of shift reports and found no entries, firstly, in acknowledgment of staff to staff communication of the concerns, and, secondly, that registered staff had assessed the resident's changing condition.

** Inspector reviewed the evening shift progress notes and found them to be confusing in establishing the time line of events. Three notes are found, each having a different time for when the PSW Staff notified Registered Staff with a request to assess the resident. Two of these notes, by the same staff person, are made as "late entries" and occur 6 hours after the resident's demise. The first of these "late entry" notations states "vital signs taken". No values are found for the vital signs taken.

The licensee failed to ensure that resident was not neglected by the licensee or staff. [LTCA,2007 S.O.2007,c.8, s.19.1]

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 that ensures residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. March 21, 2012, Inspector observed direct care to residents at breakfast service on the second floor. Inspector observed a resident seated at table with medications in a cup on the table top. Resident was in the process of taking the pills. Resident's back was to the dining room door and corridor. No registered staff was in the room to observe the resident to take the medications.

The home has not ensured that in regards to their medication management system, the written policies and protocols were not implemented in accordance with evidence-based practices and, in accordance with prevailing practices. i.e. College of Nurses Standards)[O.Reg.79/10, s.114.(3)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. ****Staff interviews confirmed that a resident was experiencing a change in health status on the night and subsequent day shift. Staff interviewed confirmed that they communicated their concerns to the Registered Staff on duty on those shifts. Inspector reviewed the resident's health care records and the unit's end of shift reports and found no entries, firstly, in acknowledgment of staff to staff communication of the concerns, and, secondly, that registered staff had assessed the resident's changing condition.

**Inspector reviewed the evening shift progress notes and found them to be confusing in establishing the time line of events. Three notes are found, each having a different time for when the PSW Staff notified Registered Staff with a request to assess the resident. Two of these notes, by the same staff person, are made as "late entries" and occur 6 hours after resident's demise. The first of these "late entry" notations states "vital signs taken". No values are entered for the vital signs taken.

The resident requiring end-of-life care did not receive care in a manner that met her needs
[O.Reg.79/10, s. 42.]

Issued on this 30th day of March, 2012

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

Monique G. Berger - Inspector 151.