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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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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
Jun 6, 7, 8, 22, 2012	2012_027192_0028	Critical Incident

Licensee/Titulaire de permis

BLACKADAR CONTINUING CARE CENTRE INC.
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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

BLACKADAR CONTINUING CARE CENTRE
101 CREIGHTON ROAD, DUNDAS, ON, L9H-3B7

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 Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents related to H-000527-12 and H-000963-12.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure, consultation notes and observed resident care areas.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Pain

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. (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. The licensee failed 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 resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

a) A specified resident sustained a fall in 2012 that resulted in an injury. The plan of care in effect at the time, dated as printed in 2011 and currently in effect does not include changes to the provision of care related to the management of the injury. Documentation in 2012 indicates the resident was utilizing a medical device.

b) Record review and interview confirm that no pain assessment was completed. The plan of care for the specified resident does not include the potential for pain in the area of the injury.

2. The licensee failed to ensure that care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

a) A specified resident sustained a fall in 2012, resulting in transfer to hospital and diagnosis of an injury.

b) The plan of care in effect at the time of the fall indicated that the resident was to be assisted by two staff.

c) Interview and documentation review confirms that only one staff member was present at the time of the fall resulting in injury, contrary to the plan of care.

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 is based on an assessment of the resident and the resident's needs and preferences and ensuring that care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records Specifically failed to comply with the following subsections:

s. 8. (1) 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 applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [r. 8. (1)(b)]

The homes policy "Pain" 05-08-01 indicates that:
Residents who express new pain or an exacerbation of existing pain will have a pain assessment completed at the time of pain expression.

a) An identified resident fell in 2012 and sustained an injury. On return to the home the resident complained of pain, as necessary analgesic was provided to the resident and in 2012 the physician increased the routine analgesic, identifying that the staff had noted an increase in behaviours related to pain. No pain assessment was completed for the identified resident.

b) An identified resident was demonstrating daily behaviours of aggression and resistance directed at staff and in 2012 complained of pain. No pain assessment was completed. In 2012 no interventions to relieve the identified pain were initiated.

On page 3 of 8 of the Pain Policy #9 states: Each time a PRN (as necessary) pain medication is given staff are to complete the Pain Flow Sheet prior to the administration of PRN medication and then again 30 minutes to 1 hour after medication administration. For cognitively well resident the numeric scale is to be used; for cognitively impaired residents the faces scale is to be used.

a) A specified resident received PRN analgesic in 2012 as documented on the Medication Administration Record. No Pain Flow Sheet was evident in the medical record. Interview confirms no Pain Flow Sheet has been completed for resident 003.

Issued on this 22nd day of June, 2012

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