Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
November 18,19,2010	2010-173-9552-18Nov105412	Complaint Inspection Log # H00634, CIS Inspection Log # H02404

Licensee/Titulaire
City of Hamilton
77 James St. N, Suite 400, Hamilton, Ontario L8R 2K3

Long-Term Care Home/Foyer de soins de longue durée
Macassa Lodge
701 Upper Sherman Ave, Hamilton Ontario L8v 3M7

Name of Inspector(s)/Nom de l'inspecteur(s)
Lesa Wulff - #173 – LTC Inspector – Nursing

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: Director of Care, Assistant Director of Care, Social Worker, Registered Staff, Personal Support Workers and Residents.

During the course of the inspection, the inspector: reviewed clinical health records, medication administration records, assessments, plans of care, policy and procedures and reviewed falls program.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse and Neglect Inspection Protocol
Falls management Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
3 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.23(1)(a)(1)
23(1) Every licensee of the long-term care home shall ensure that
(a) Every alleged, suspected or witnessed incident of the following, that the licensee knows of, or that is reported to the licensee, is immediately investigated
(1) abuse of a resident by anyone

Findings:

1. The licensee failed to investigate the allegations of abuse reported to staff on two occasions:
2. An identified resident reported to staff after a fall sustained in the washroom, that the fall occurred due to rough handling and rushing by staff. The resident indicated that the staff person grabbed the resident by the arm and caused the resident to lose balance and fall. This was documented as reported in the clinical record in 2010 by RN on duty as well as indicating that staff were to be spoken to regarding the residents fall and the resident's verbalization that staff were rough and pushed the resident. This incident as reported, did not initiate an investigation into the allegations of abuse/rough handling.
3. An identified resident reported to staff at a post admission care conference held in 2010 that night staff are impatient and harsh. During this meeting the RN, Social worker, Nurse Manager, Physio Therapist, resident and family were present. Notes were taken by the social worker. This incident as reported, did not initiate an investigation into the allegations.

Inspector ID #:	173

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 related to developing a process to ensure that all reports of alleged abuse of a resident are investigated immediately, to be implemented voluntarily.

WN #2: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(1)(c)
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
(c) clear direction to staff and others who provide direct care to the resident.

Findings:

1. The licensee did not provide a written plan of care that sets out clear direction to staff or others who provide direct care to a resident:
2. An identified resident reviewed is ambulatory and cognitively capable of daily care decisions according to the clinical record. During interview with the staff on the home area, staff indicated that this resident was fiercely independent, used a wheeled walker to ambulate and transferred by self quite frequently. Staff indicated that the family of the resident understood the risks to the resident and encouraged the resident's goal of continued independence. This information was not captured on the plan of care developed for falls management with interventions to mitigate risks with the identified goal in mind.
3. An identified resident was identified as having sustained a fracture as a result of climbing out of bed. The incident was unwitnessed by staff, who found bruising on the residents arm during AM care and reported the incident to registered staff. The plan of care for falls for the resident did not include the behaviour noted related to self transferring as identified in progress notes on at least two occasions (September, 2010 and October, 2010). The plan of care interventions did not include strategies to address assessed care need of the resident based on these behaviours.

Inspector ID #:	173

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 related to developing a process to ensure that the plan of care sets out clear direction to staff and others, to be implemented voluntarily.

WN #3: The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8 s.6(11)(b)
6(11) When a resident is reassessed and the plan of care reviewed and revised, if the plan of care is being revised because care set out in the plan has not been effective
(b) the licensee shall ensure that different approaches are considered in the revision of the plan of care

Findings:

1. The licensee did not consider or include different approaches to care when the care set out in the plan of care has not been effective.
2. Staff were able to identify during interview regarding an identified resident, aspects of the resident's personality played a role in the recurrent falls experienced by the resident. These included significant hearing and vision loss that impaired the resident's communication, the resident's ability to navigate surroundings and maintain safety. The staff had communication with the resident and family to indicate that the resident wanted to stay ambulatory despite these risks. The plan of care for falls had not been revised since the resident's admission in March 2010 to include wishes of the resident/family related to remaining ambulatory in spite of numerous falls. Interventions on the plan of care have not been revised to ensure that different approaches are considered.

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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 related to developing a process to ensure that different approaches to care are considered when the plan of care is reviewed and found to be ineffective, to be implemented voluntarily.

[Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. Revised August 30, 2011 for the purpose of publication
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).