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


**Public Copy/Copie du public**

| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| May 10, 31, Jun 5, 6, 13, Jul 12, 2012 | 2012_027192_0023 | Complaint |

**Licensee/Titulaire de permis**

CITY OF HAMILTON
77 James Street North, Suite 400, HAMILTON, ON, L8R-2K3

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

MACASSA LODGE
701 UPPER SHERMAN AVENUE, HAMILTON, ON, L8V-3M7

**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 Nurse Managers, Registered Nurses, Registered Practical Nurses, and Personal Support Workers related to H-000352-12.**

**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:**

**Falls Prevention**

**Pain**

**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. (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 was 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. [s. 6. (10) (b)]

a) Resident 001 was transferred to hospital in 2011 and returned to the home in 2011. On return from hospital there is no evidence of assessment and updating of the plan of care in relation to changes in resident 001's care needs. There is no evidence of a head to toe assessment having been completed in spite of resident 001 having an incision and documentation on the daily nursing report that the resident had bruising on the arms. Interview with registered staff and a nurse manager confirm there are no documented assessments on return from hospital and the plan of care was not updated to reflect changes in resident 001's care needs.
A review of the flow sheet indicates that the resident received total assistance with eating, toileting, bed mobility, hygiene and grooming and was incontinent of bowel and bladder. The plan of care in effect at the time indicates the resident is independent with eating, requires extensive assistance with hygiene and grooming, requires limited assistance with bed mobility and toileting and is continent of bowel and bladder. Interview with registered staff and a nurse manager confirm that the plan of care provided does not reflect the change in care required by resident 001 at the time of readmission from hospital.

b) Resident 003 returned from hospital in 2012. There were identified changes in the residents care needs on return to the home. The resident complained of pain, no pain assessment was completed; the resident had previously been identified to be at high risk of falls, no fall risk assessment was completed. The plan of care was not updated to reflect changes in the residents condition. A Kardex was printed in 2012 and in use for a three month period - no changes were made to the Kardex to reflect the increased needs of the resident, including that the resident was incontinent of urine. The plan of care printed in 2012 indicates that the resident transfers independently without assistance, flow sheet documentation indicates the resident was not transferred and required extensive assistance in 2012. Interview with the Registered Nurse confirms that the Kardex and Plan of Care do not reflect changes in resident 003's condition on return from hospital in 2012.

*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 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, to be implemented voluntarily.***

---

**WN #2: 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. The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital. [r. 50. (2) (a) (ii)]

a) Resident 001 did not receive a skin assessment by a member of the registered nursing staff upon return from hospital in 2011. The home was unable to provide documentation of assessment of the dressing or incision and the treatment record provided, did not include care required for the incision. Interview with a registered nurse confirms that resident 001 returned to the home with an incision closed with staples. Documentation does not indicate when the staples were removed but does indicate in a physician note in 2011 that the incision is well healed.

b) Resident 003 returned from hospital in 2012. The resident was identified to have altered skin integrity. Documentation review and interview confirm that no head to toe assessment was completed on return from hospitalization.

---

**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 failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. [ r. 52. (2)]

Resident 003 was readmitted from hospital in 2012. Documentation review identified that in 2012 the resident complained of pain and was told they could not receive analgesic due to the length of time since last receiving medication. In 2012 the resident continued to complain of severe pain. Interview with the registered nurse confirms that no pain assessment using a clinically appropriate assessment instrument specifically designed for this purpose was completed for this 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 when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

---

**WN #4: 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 failed to 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. [r. 30. (2)]

Resident 001 returned from hospital in 2011. Interview with a registered nurse confirmed that resident 001 had an incision closed with staples. Documentation provided by the home (progress notes and treatment administration record) does not include the presence of an incision, care of the incision, or removal of the staples. A physician note in 2011 confirms the healing of the incision.

---

**WN #5: 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. A) The homes policy "Pain Management" updated September 15, 2010 indicates that a formal (pain) re-assessment will be completed: upon sudden change in condition with onset of pain and when scheduled pain medication does not relieve the pain or the pain remains regardless of interventions (unmanaged pain).

i) Resident 003 sustained a sudden onset of pain in 2012. No pain assessment was completed.
Resident 003 complained of pain in spite of regular doses of analgesic. No pain assessment was completed.

B) The homes policy titled "Risk Management" updated September 1, 2010 indicates that:
1. The Falls Risk Assessment Tool will be completed on admission, with each quarterly and as needed with changes in resident condition.

i) Resident number 001 was hospitalized. The resident returned to the home in 2011. Flow sheet documentation of care provided by the personal support workers indicates that resident 001's condition had changed in that the resident went from being independent in some activities of daily living to requiring total assistance with care and had become incontinent of bowel and bladder. Documentation review and interview confirm that no Falls Risk Assessment was completed on resident 001's return from hospital with a change in condition. In 2011 resident 001 sustained a fall while attempting to transfer independently from the wheelchair to the bed.

ii) Resident number 003 was hospitalized. The resident returned to the home in 2012 with a change in health status. Documentation review and interview confirm that no "Fall Risk Assessment Tool" was completed for resident 003 on return from hospital in spite of the resident having been identified to be at high risk for falls prior to the change in condition.

**Issued on this 13th day of July, 2012**

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

Debra Saville (190)