Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 26, 2018	2018_702197_0008	001466-18, 002898-18, 004611-18, 006170-18, 007048-18	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Heartwood
201 - 11th Street East CORNWALL ON K6H 2Y6

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 4-6, 9, 10, 2018

The following complaint logs were inspected as part of this report:
001466-18 - related to communication amongst staff and assessment of residents
002898-18 - related to plan of care, falls prevention and medication administration
004611-18 - related to an alleged sexual abuse
006170-18 - related to falls prevention, call bell placement and dietary concerns
007048-18 - related to staffing levels

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Activity Manager, the Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector also observed resident care and reviewed resident's health care records, the home's staffing plan, policies related to weight monitoring and falls prevention and the activity calendar.

The following Inspection Protocols were used during this inspection:
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Safe and Secure Home
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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:

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The following findings are related to logs 001466-18 and 006170-18:

The licensee has failed to ensure that resident #002's Power of Attorney (POA) for Care was provided the opportunity to participate fully in the development and implementation of the plan of care.

Resident #002's diet was changed two times over a specified time period.

The resident's POA for Care indicated that they were not notified of these changes when they occurred and did not become aware until they visited the resident in the home.

The DOC and Administrator both indicated that their expectation would be that the Registered Dietitian (RD) would call the POA to notify them at the time the diet order was changed.

The RD was interviewed and indicated that they do not call POA's when diet orders are changed and indicated that the Registered Nurse (RN) would be the one to notify the POA.

Upon review of the resident's health care record there was no evidence that either the RD or the RN had called to notify resident #002's POA for care of the resident's diet changes. [s. 6. (5)]

2. On a specified date, resident #002 fell in their bedroom and was transferred to hospital for further assessment. Upon return from the hospital later that day, resident #002's POA indicated to the Inspector that the resident's bedroom has been rearranged without

any discussion or consultation with either the resident or the POA.

Upon review of resident #002's health care record, there was no indication that the resident's room had been rearranged, by whom or why.

Inspector #197 conducted interviews with both the Administrator and the Director of Care. They both indicated they were unaware resident #002's room had been rearranged and who had made the decision that it needed to be done. The DOC walked down to the resident's room and confirmed that the resident's room had been rearranged. The DOC indicated they would speak to staff and find out what had occurred.

During a later interview with the DOC, they indicated that housekeeping staff stated that two pieces of the resident's furniture were moved the day the resident fell because EMS (Emergency Medical Services) had a hard time getting into the resident's room. The DOC also stated that the resident's bed was later moved but was unsure who moved it and when.

Both the Director of Care and Administrator agreed that resident #002 and/or the resident's POA for care should have been notified prior to the rearrangement of the resident's room.

The POA for Care of resident #002 was not notified of diet changes and neither resident #002 or their POA for care were notified of the rearrangement of the resident's bedroom furniture prior to the change being made and therefore not provided the opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

3. The following finding is related to log 002898-18:

The licensee has failed to ensure that the care set out in the plan of care for resident #003, was provided as specified in the plan.

Resident #003's care plan at the time of the inspection indicated that the resident has been assessed as high risk for falls and that a specific intervention should be in place to help prevent falls.

On a specified date, Inspector #197 observed resident #003 to be sitting in a chair outside the dining room without the specified intervention in place.

Inspector stayed in the area and approximately 15 minutes later, PSW #108 was observed to put the specified intervention into place.

The following day, resident #003 was observed by Inspector #197 to be sitting outside the dining room in a chair and the specified intervention was not in place. Staff were observed in the area taking residents to and from the dining room. A short time later, resident #003 was observed to be seated in a chair outside the dining room and remained without the specified intervention in place and this time there were no staff around.

Inspector #197 asked PSW #107 if the specified intervention should be be in place for resident #003. The PSW stated that the specified intervention should be in place and proceeded to implement the intervention for resident #003. The PSW also confirmed that the resident was at risk for falls and had fallen recently.

During an interview with RPN #110, they indicated that resident #003 should have the specified intervention in place at all times. The RPN further stated that staff do forget at times and need to be reminded. The RPN also indicated to the inspector that there is another specified intervention that should be in place for resident #003 when they are in bed.

At 1503 hours on the same day, resident #003 was observed in bed asleep with the specified intervention in place.

During interviews with the Director of Care, they indicated that the resident is to have the first specified intervention in place at all times as indicated in their care plan. The DOC indicated that the intervention that RPN #110 stated should be in place when resident #003 is in bed, is not part of the resident's care plan and should not be in place because it could put resident #003 at further risk for falls.

Inspector #197 noted upon looking at resident #003's care plan that it does not direct staff to do the specified intervention mentioned by RPN #110 while the resident is in bed.

Care set out in the plan of care was not provided to resident #003 as specified in the plan since the resident was observed in a chair outside the dining room on two occasions during the inspection without a specified intervention in place. The resident was also observed in bed with another intervention in place that was not indicated and was identified by the DOC to put the resident at an increased risk of falls. [s. 6. (7)]

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 resident, the resident's substitute decision-maker (SDM), if any, and any other persons designated by the resident or SDM are given the opportunity to participate fully in the development and implementation of the resident's care plan; and that the care set out in the plan of 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:

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 O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The following finding is related to log 006170-18:

The licensee has failed to comply with their fall prevention and injury reduction procedure with respect to resident #002.

O. Reg. 79/10, s. 48(1) indicates that every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The home's procedure CARE5-010.05 titled "Fall Prevention and Injury Reduction" dated October 14, 2016 instructs staff to do the following when a fall has occurred:
- An Interdisciplinary Team huddle is conducted on the same shift that the fall occurred. Follow the Post-Fall Huddle Questions to collect the information needed to conduct a root cause analysis of the fall.
- Fall Risk Screen - complete if not high risk and quarterly by Falls lead.

The resident's current care plan indicates that the resident has been assessed as medium risk for falls.

Resident #002 had an unwitnessed fall on a specified date. A post-fall assessment was completed by registered staff and the resident was sent to hospital for further assessment. Upon review of resident #002's electronic and paper chart, it was noted that the Post-Fall Huddle Questions were not completed and that a Fall Risk Screen was not done.

An interview with RPN #105 confirmed that an interdisciplinary team huddle was not completed for resident #002's fall.

Interviews with the Director of Care indicated that the home's expectation is that after each fall, an Interdisciplinary Team huddle and the Post-Fall Huddle Questions form are completed. In addition, if the resident is not already assessed at high risk for falls, then staff are expected to complete a Fall Risk Screen after a resident has fallen.

The home did not follow their Fall Prevention and Injury Reduction procedure in that they did not complete an Interdisciplinary Team huddle or a Fall Risk Screen related to resident #002's fall on March 24, 2018. [s. 8. (1) (a),s. 8. (1) (b)]

2. The following finding is related to log 002898-18:

The licensee has failed to comply with their weight and height monitoring procedure with respect to resident #003.

O. Reg. 79/10, s. 68 (2) states that every licensee of a long-term care home shall ensure that their nutrition care and hydration program includes (e) a weight monitoring system to measure and record (i) the monthly weights of each resident.

The home's procedure CARE7-O10.03 titled "LTC – Weight and Height Monitoring" dated August 31, 2016, instructs staff to do the following:
- the RD/NM/Designate reviews the weight report monthly to ensure all significant weight changes and undesirable insignificant weight changes have been addressed
- Significant weight variances and interventions will be communicated to the Resident/Substitute Decision Maker (SDM)

Significant weight changes are identified as follows in the home's procedure:
- Weight loss or gain of greater than or equal to 5 per cent of total body weight over one month
- Weight loss or gain of greater than or equal to 7.5 per cent of total body weight over three months
- Weight loss or gain of greater than or equal to 10 per cent of total body weight over six months
- or any weight change that compromises the resident's health status

On a specified date, resident #003's weight was recorded and a loss of 6.1 percent body weight in one month was identified.

Nine days later, a referral was made to the Registered Dietitian (RD) to assess the weight change.

The specified weight change for resident #003 was not assessed by the RD until approximately 3 months later.

The home's RD was interviewed and indicated that about 25 per cent of residents triggered for a significant weight change in the same month as resident #003 and the RD questioned the accuracy of the weights. The Inspector asked what the expected timeline of the home is for assessing significant weight changes and the RD said they were unsure. The RD also stated during the interview that it is not their current practice to notify families of significant weight changes and stated the RN would do this.

The Director of Care was interviewed and stated that the expectation would be for the RD to assess significant weight changes within a couple of weeks of the weight change being identified. Both the Director of Care and Administrator indicated during interviews that the Registered Dietitian should notify residents/families of any significant weight changes when they occur.

The family indicated to the inspector that they were not notified of the resident's significant weight change from the specified month, until approximately 3 months later during the annual care conference.

The RD did not assess the significant weight loss for resident #003 as per the home's procedure and there was no evidence in resident #003's health care record that the SDM had been notified of the significant weight change that occurred in the specified month. [s. 8. (1) (a),s. 8. (1) (b)]

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 licensee's fall prevention and injury reduction and weight and height monitoring procedures are complied with, to be implemented voluntarily.

Issued on this 4th day of May, 2018

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

Original report signed by the inspector.