Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 2, 2014	2014_286547_0013	O-000353-14	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 30 and May 1, 2014

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the Staff Development RN, a RAI-coordinator, Registered and non-Registered staff, a Physiotherapist, a Resident and a family member.

During the course of the inspection, the inspector(s) reviewed health care records, reviewed policies related to Adverse Event Management LP-C-40 revised April30, 2013, Resident non-Abuse-Ontario , LP-C-20-ON revised October 2012, re-indexed March 2013, Safety in Ambulating, Lifting and Transferring Program HS16-P-10 revised January 2014, reviewed census records, reviewed the home's investigation report, made observations of direct resident care and Staff to Resident interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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:

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 2007, c. 8, s. 6 (4).
(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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(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 staff and others involved in the different aspects of care for Resident #001, collaborated with each other, in the assessment of the resident after an incident on a specified date in April, 2014 in that their assessments were not integrated, consistent or complementary to each other in the development and implementation of the plan of care.

Inspector #547 conducted an inspection for a critical incident reported by the home to the Director regarding an unusual occurrence whereby Resident #001 had an x-ray which identified a fractured area with no documented incident involving this resident. Resident #001 was admitted to the home ten years ago and had diagnosis of an unspecified bone condition.

The Executive Director reported to Inspector #547 that after an internal investigation was conducted regarding Resident #001's injury ,it was discovered that Staff #101 did not report an incident with the resident that occurred on a specified date in April 2014.

Inspector #547 conducted a telephone interview with Staff #101. Staff #101 reported that during the evening shift on a specified date in April, 2014 that Staff #101 mobilized the resident's wheelchair after supper from the dining room down the hallway towards the resident's room when the resident caught his/her injured area on

the edge of a metal door frame. Staff #101 indicated she backed up the wheelchair and repositioned Resident #001. Staff #101 indicated the resident did not show any signs of pain. Staff #101 transferred the resident to bed and noted the resident did not show signs of injury or pain. Staff #101 confirmed she did not report this incident to any registered staff.

Staff #102 reported to Inspector #547 in an interview that Resident #001's positioning was noted to be "very curled up in bed, almost fetal position" when the day shift began on another specified date in April, 2014. Staff#102 observed during the residents transfer from bed to wheelchair that the resident kept holding the injured area with facial grimace. Staff #102 noted small bruises and edema to a specified injured area and the resident had facial grimace when this area was palpated. Staff #102 reported to Registered Staff #105 who assessed the resident and indicated registered staff would monitor the resident. Registered Staff #105 did not report her assessment of Resident #001 to the Registered Staff #100, in charge on that shift.

Interview with Registered Staff #100 indicated Staff #106 worked the evening shift on a specified date in April, 2014, reported the resident was displaying signs of discomfort to a specified area on the resident which appeared injured. Staff #100 assessed the resident, and noted that the resident's injured area was slightly bruised with discomfort upon movement.

The resident's family member was called and came to look at the resident's injured area, indicated it was difficult to know if the area was injured as the resident had a previous injury many years ago to this same area and noted it was not very swollen or bruised. The Resident's family member did not want the resident to go to hospital for assessment until another specified date in April, 2014 as he/she wanted to accompany the resident and was not available until then. The home did continue to monitor the resident for any further signs of possible injury and discomfort. Pain medication had been provided until the resident was sent to hospital for x-ray.

2. The Licensee has failed to ensure that reassessments and revision are required to the plan of care when the resident's care needs change regarding Resident #001 who was diagnosed with a fracture on a specified date in April, 2014 with cast in place.

In an interview with Staff #100, she indicated that non-registered staff refer to the written care plan at the front of the resident charts regarding the plan of care for

residents. This written care plan for Resident #001 was reviewed by both Inspector #547 and Staff #100 whereby it was noted that the care plan was not updated with the change in care needs related to the resident’s fracture. The last review date for this written care plan on file for Resident #001 is a specified date in June, 2013.

Staff#102 reported to Inspector #547 that non-registered staff follow the care requirements for the residents they care for on the home’s Point of Care system and whatever information is given to them in shift report.

Inspector #547 interviewed a RAI coordinator concerning Resident #001’s care plan in Point Click Care, as the last care plan completed was a specified date in April, 2014 prior to the incident for the resident. She explained that when a significant change occurs, or changes to the care plan are required, the registered staff are expected to edit the last completed care plan and add the new focus related to this change. She also indicated that non-registered staff can access the computers at any time by asking the registered staff to open the computer and nursing station rooms however non-registered staff would not know how to locate the edited care plan as they were not trained for Point Click Care at this time.

Inspector #547 interviewed the Executive Director as to the home's expectations regarding how staff access the most recent care plan for residents. The ED indicated that registered staff are to update residents electronic care plans in Point Click Care when a change is required. Inspector #547 observed the Point Of Care and most recent edited care plan for Resident #001 in the company of the RAI coordinator and Executive Director whereby the care needs and interventions for Resident #001's fracture and cast were not reflected anywhere for staff who provide direct care to the resident. [s. 6. (10) (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 regarding reassessments and revisions made to resident plan of care when the resident's needs change and made accessible for all staff who provide direct care, to be implemented voluntarily.

Issued on this 3rd day of July, 2014

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