Ontario Ministry of Health and Long-Term Care

Inspection Report under *LTCHA, 2007* Public Copy

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

Hamilton Service Area Office
119 King St. W., 11th Floor
Hamilton, ON
L8P 4Y7

Telephone: 905-546-8294
Toll-Free: 1-800-461-7137

Facsimile: 905-546-8255

Ministére de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Téléphone: 905-546-8294
Toll-Free: 1-800-461-7137

Télécopieur: 905-546-8255

Type of inspection/Genre d'inspection:	Complaint **PUBLIC REPORT**
Inspection No/d'inspection:	2101-108-2364-05JUL122420
Dates of inspection/Date de l'inspection:	July 6, 7, 2010
Report date:	July 13 2010
Long-Term Care Home/ Établissement de soins de longue durée:	VERSA CARE ST. CATHERINES 168 Scott Street St. Catharines, Ontario L2N 1H2
Licensee:	REVERA LONG TERM CARE INC. 55 Standish Court, 8th Floor Mississauga ON L5R 4B2
Name of Inspector(s):	REBECCA WYLIE (ID # 108)

WN = Written Notification
VPC = Plan of Correction
CO = Compliance Order
WAO = Work and Activity Order
DR = Written Notification and referral to the Director

SUMMARY OF INSPECTION

THIS INSPECTION WAS COMMENCED AFTER RECEIPT OF A COMPLAINT VIA A FAX TRANSMISSION TO THE HAMILTON SERVICE AREA OFFICE. CONCERNS WERE EXPRESSED AROUND THE LTC HOME'S INADEQUATE HANDLING OF A RESIDENT'S TREATMENT AND CARE ISSUES IN RELATION TO FOLLOW- UP TO REPORTED FALLS. THE RESIDENT IS DECEASED.

THE INSPECTION WAS CONDUCTED BY ONE (1) INSPECTOR IDENTIFIED ABOVE. THE ON-SITE INSPECTION OCCURRED ON JULY 6 AND 7, 2010 WITH ONE (1) INSPECTOR BEING PRESENT ON BOTH DAYS.

DURING THE COURSE OF THE INSPECTION, THE INSPECTOR SPOKE WITH MEMBERS OF THE MANAGEMENT TEAM , INCLUDING THE REGIONAL MANAGER OF CLINICAL SERVICES, THE ADMINISTRATOR , DIRECTOR AND ASSSITANT DIRECTOR OF CARE, MEDICAL DIRECTOR (ALSO ATTENDING PHYSICIAN) , STAFF ON THE HOME AREA, CONTRACTED PHSIOTHERAPIST AND RESTORATIVE CARE AIDE. A REVIEW OF THE RESIDENT'S HEALTH RECORD, POLICIES AND PROCEDURES AROUND FALLS ASSESSMENT AND MANAGEMENT PROGRAM, RESTRAINT, TREATMENT RISK MANAGEMENT, CONTRACTS WITH PHARMACY AND LABORATORY AND MEDICAL DIRECTIVES WERE COMPLETED,CURRENT LAB RESULTS FOR ALL RESIDENTS ON A SPECIFIC TREATMENT WERE REVIEWED IN THE LTC HOME FOR FOLLOW-UP TREATMENT AS NEEDED.

THE FOLLOWING INSPECTION PROTOCOLS WERE USED IN PART OR IN WHOLE DURING THIS INSPECTION:

- HOSPITALIZATION AND DEATH INSPECTION PROTOCOL
- FALL PREVENTION INSPECTION PROTOCOL
- MEDICATION INSPECTION PROTOCOL

9 FINDINGS OF NON-COMPLIANCE WERE FOUND DURING THIS INSPECTION. THE FOLLOWING ACTION WAS TAKEN:
9 WN
1 VPC

NON-COMPLIANCE

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.)

WN #1: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long-Term Care Homes Program Manual Standards and Criteria**

Criteria B2.4 : Each resident's plan of care shall reflect his/her current strengths, abilities, preferences, needs, goals, safety/security risks, and decisions including advance directives provided by the resident or any substitute decisions provided by the lawfully authorized person . The plan of care shall give clear directions to staff providing care.

Findings:

1. An identified resident was assessed for falls on May 29, 2010 and June 11, 2010. The assessment score placed the resident in the category for high risk for falls. The plan of care did identify at high risk for falls and for the staff to have "commonly used articles in easy reach." Front line staff were using a front-fastening seatbelt, a bed alarm and a chair alarm to manage risk for falls, none of which were identified on the plan of care. There were no clear directions for staff on the plan of care for these interventions.
2. An identified resident was receiving a treatment. The policy in the home requires that the interventions for management of this treatment to be identified on the plan of care. There were no interventions identified on the plan of care to provide staff with clear direction on managing this treatment.
3. Assessments of identified resident were completed by the different disciplines and are not reflective of a comprehensive assessment and evaluation. In discussion with the physiotherapist and restorative aide there were differences of opinion in the usage of a restraint for safety. As a result there were not clear directions for staff on the plan of care to manage the risk for falls.
4. A fall assessment was last completed on May 10, 2010. An identified resident was discussed by the interdisciplinary team at the Fall Prevention Committee meeting on April 8, 2010 and June 2, 2010. Interventions discussed were not included in the plan of care related to risk of falls to identify interventions for

management of high risk for falls.

INSPECTOR ID# - 108

WN #2: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long -Term Care Homes Program Manual Standards and Criteria**

Criteria B2.6. Each resident's plan of care shall be reviewed and where necessary revised, at least quarterly, by the physician, nursing staff, the dietician or food service supervisor, and other care team members as appropriate.

Findings:

1. The only intervention on the plan of care was to have "commonly used articles in easy reach." The last Falls Risk Assessment was completed on May 10,2010. The plan of care was not reviewed and revised to outline management of the identified high risk for falls after occurrence of two falls in two months in 2010.
2. Resident Assessment Instrument-Minimum Data Set(RAI-MDS) summary document "Trigger Listing and RAP Information" dated April 12, 2010 did not have a comprehensive assessment and evaluation of identified Resident Assessment Protocol(RAP) for falls and behaviours.
3. Target dates for designated goals for falls, behaviours and mobility were noted to be past the date for assessment and evaluation on the plan of care accessible to the Personal Support Workers(PSWs). Noted date for reassessment and evaluation was April 30, 2010.
4. An identified resident was discussed at the Falls Prevention Meetings on April 8, 2010 and June 2, 2010. Interventions discussed at these meetings were not included in the plan of care for the resident.
5. Four incident reports reviewed for three months in 2010, they were not completed in full. The section referencing "MD notified" reflects notification by a Registered staff member by either a phone call or a note left for the physician. There is no supportive documentation on the resident's health record to support that the resident was further assessed by the physician after notified on all four occasions.

INSPECTOR ID# - 108

WN #3: THE LICENSEE HAS FAILED TO COMPLY WITH **The Nursing Homes Act , RSO 1990 chap.N.7, s. 20.10 (a), (b) and (c)**

20.10 A licensee of a nursing home shall ensure that,
(a) the requirements of each resident of the nursing home are assessed on an ongoing basis;
(b) the plan of care is developed for each resident to meet the resident's requirements;
(c) the plan of care is revised as necessary when the resident's requirements change;

Findings:

1. The only intervention on the plan of care was to have "commonly used articles in easy reach." The last Falls Risk Assessment was completed on May 10, 2010. The plan of care was not reviewed and revised to outline management of the identified resident's high risk for falls after occurrence of two falls.
2. RAI-MDS summary document "Trigger Listing and RAP Information" dated April 12, 2010 did not have a comprehensive assessment and evaluation of identified RAP for falls and behaviours.
3. Target dates for designated goals for falls, behaviours and mobility were noted to be past the due date for reassessment and evaluation. Noted date for reassessment and evaluation was April 30, 2010.
4. An identified resident was discussed at the Falls Prevention Meetings on April 8, 2010 and June 2, 2010. Interventions discussed at these meetings were not included in the plan of care for the resident
5. Four incident reports were reviewed for three months in 2010,they were not completed in full. The section referencing "MD notified" reflects notification by a Registered staff member by either a phone call or a note left for the physician. There is no supportive documentation on the resident's health record to support that the resident was further assessed by the physician after notified on all four occasions.

INSPECTOR ID# - 108

WN #4: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long- Term Care Homes Program Manual Standards and Criteria**

CRITERIA **B2.5; Each resident's plan of care shall be accessible to the members of the health care team who provide care and services to the residents. Pertinent information, including changes in the resident's condition, shall be communicated to staff providing care.**

Findings:

1. Plan of care for an identified resident was updated on April 26, 2010 for a change in diet. This change was noted in the computerized copy of the plan of care but not on the plan of care provided to the PSW staff.

INSPECTOR ID# **- 108**

WN #5: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long-Term Care Homes Program Manual Standards and Criteria**

CRITERIA **B5.3; The evaluation of care and services and care outcomes shall be documented in each resident's health record.**

Findings:

1. The document entitled "Trigger Listing and RAP Information" completed on April 12, 2010 did not provide an assessment or documentation of the effectiveness of the plan of care related to falls.

INSPECTOR ID# **- 108**

WN #6: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long-Term Care Homes Program Manual Standards and Criteria.**

CRITERIA **B1.6: Each resident's care and service needs shall be reassessed at least quarterly and whenever there is a change in the resident's health status, needs or abilities.**

Findings:

1. RAP Summary dated April 12, 2010 did not reflect the change in an identified resident's health status. Falls Triggered RAP did not evaluate the usage of a front closing seatbelt while in their wheelchair. The identified resident could undo the seatbelt.
2. On June 2, 2010 the interdisciplinary team discussed an identified resident at the Falls Prevention Committee meeting. Additional interventions of a chair and bed alarm were noted in the minutes of the Falls Prevention Committee meeting of June 2nd, 2010. Front line staff implemented these interventions but the plan of care did not include these directions.
3. Documentation in the resident records supports assessment by the nursing staff of an identified resident following two separate falls. Head injury routine assessments were completed after the above noted falls. However, areas of bruising identified by staff on an identified resident, along with changes in pupil reaction were not assessed and evaluated in relation to a treatment received as there was no direction in the plan of care for monitoring the treatment.

INSPECTOR ID# **- 108**

WN #7: THE LICENSEE HAS FAILED TO COMPLY WITH THE Long-Term Care Homes Program Manual Standards and Criteria.

Criteria M1.18: The facility's policies, procedures, and work routines shall be followed in the provision of care

and services. Staff shall be reinstructed when required.

Findings:

1. The home did not implement a plan of care to address an identified resident's high risk for falls. The home's policy and procedures for "Fall Interventions Risk Management Program" was not followed as there were no interventions identified on the plan of care for management of an identified resident's high risk for falls.
2. The nursing staff did not assess/ monitor an identified resident's treatment as per the home's policy. The home's pharmacy policy and procedure specific to this treatment was not followed in relation to the management of an identified resident's symptoms.

INSPECTOR ID# - **108**

WN # 8*: THE LICENSEE HAS FAILED TO COMPLY WITH* THE **Long-Term Care Homes Program Manual Standards and Criteria**

Criteria C1.19: Each resident's response to medications and treatments shall be monitored and evaluated and changes shall be made as required.

Findings:

1. There is no documentation supporting that the following observations were assessed and evaluated by the nursing staff as concerns related to the treatment that an identified resident received daily:
    a) An identified resident had noted symptoms as per Head to Toe assessment tools completed post two falls.
    b) Head Injury routine assessments documented and completed for both of the above identified falls reflect that the resident's pupils were brisk or sluggish to react.
    c) Documentation in the progress notes post fall indicates injury to mouth.
2. Physician quarterly medication reviews were completed by the attending physician. Physician's order for lab work for treatment was in place. Results were monitored by physician with the exception of one occasion in 2010. Lab report for testing on this occasion was not tracked for a copy of result by the Long-Term Care (LTC) home. Lab result was mailed to the attending physician's office only and the result not reported to the home. The date which the physician received the report was not able to be confirmed. From June 10, 2010 until resident deceased there was no tracking of the resident's lab results.

INSPECTOR ID# - **108**

VPC- pursuant LTCHA, 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 be implemented voluntarily. The home is to prepare a plan that includes the education of both the Registered staff and the PSWs on the monitoring and management of signs and symptoms associated with this treatment.

REQUIRED COMPLIANCE DATE FOR VPC– Immediate

WN #9: THE LICENSEE HAS FAILED TO COMPLY WITH THE **Long-Term Care Homes Program Manual Standards and Criteria**

CRITERIA **A1.11 – 2: Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.**

Findings:

1 An identified resident did not have their need for treatment and their high risk for falls management of that risk

addressed on the plan of care.

2 The identified resident's symptoms from 2 falls in two months in 2010 were not assessed and evaluated. The change in the identified resident's pupil reaction from brisk to sluggish on completed Head Injury routines was not assessed and evaluated. The identified resident's mouth was not assessed and evaluated. An identified resident's lab result June 11, 2010 was neither reported to the home nor tracked by the home.

3 Interventions of usage of a chair and bed alarm discussed by the multidisciplinary team at the Falls Prevention meeting of June 2, 2010 were not on the plan of care. The front closing seatbelt applied was not on the plan of care.

INSPECTOR ID# **- 108**

REQUIREMENT	ORDER		INSPECTOR ID#	
		Now in compliance.		

Signature of Licensee of Designated Representative Reçu pour l'établissement par	Signature of Health System Accountability and Performance Division Performance Improvement and Compliance Branch (Inspectors) Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé
	Rebecca S. Wylie #108
Name(Print): Title: Date:	Name(Print): REBECCA S. WYLIE Date: LTC Nursing Home Inspector