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
August 24, 25, 2010	2010-173-2784-19Aug112513	Critcial Incident Inspection Log # H01481

Licensee/Titulaire
Barton Retirement Inc.
1430 Upper Wellington St. , Hamilton, Ontario. L9A 5H3

Long-Term Care Home/Foyer de soins de longue durée
The Wellington Nursing Home
1430 Upper Wellington St. , Hamilton, Ontario L9A 5H3

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

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: Director of Care, Staff Education Coordinator, RAI Coordinator, Personal Support Workers, Registered Staff

During the course of the inspection, the inspector(s): reviewed archived health records, plan of care, medication and treatment records.

The following Inspection Protocols were used during this inspection:
Falls Prevention Inspection Protocol

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

[6] WN

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 **The Long Term Care Homes Program Manual Standards and Criteria.**

Criteria B1.2: The assessment process shall include determining the resident preferences. Strengths, social and personal resources, interests, health status, needs, extent of independent functioning, type and amount of support required, and decisions regarding the type of care and/or interventions, including advance directives or substitute decisions.

Findings:

1. An identified resident was admitted to the Wellington Nursing home in 2009. Information available to staff on admission indicated that this resident had a history of falls as well as significant behaviours that impacted the risk for falls. The behaviour was noted to continue in the home after admission. A falls risk assessment tool was completed in December 2009 with a score of 32 (moderate risk for falls). A second risk assessment tool was completed in March 2010 with a score of 37 (high risk for falls). An analysis of the information gathered on these tools was not used to determine the care needs for this resident related to falls management and impact decisions related to the type of care required.
2. An identified resident developed a seizure disorder in 2010 and was started on Dilantin. Several episodes of choking were also documented by staff in 2010 in the progress notes. The resident developed fever and decreased level of consciousness and was sent to hospital for assessment in 2010. The resident was diagnosed with aspiration pneumonia and sent back to the home on antibiotics. A referral for swallowing assessment was not initiated until return from hospital in spite of the residents choking episodes documented by staff prior to hospital admission.
3. An identified resident was noted in the progress notes to frequently try to climb out of bed at night. The assessment process did not determine the care needs for this resident related to this behaviour or include decisions regarding the type of care and interventions required.

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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, as least quarterly, by the physician, nursing staff, the dietician or food service supervisor, and other care team members as appropriate.

Findings:

1. An identified resident was noted to have sustained 10 falls for a specified period of time, the last resulting injury. The plan of care did not reflect and was not revised with the significant risks related to the resident's cognitive impairment, lack of comprehension or recognition of exhaustion related to excessive pacing, falls, new onset of seizures, swallowing difficulties leading to aspiration pneumonia, general deterioration of resident, use of restraint to prevent falls. Last update to the written plan of care was completed in 2010.

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WN #3: The Licensee has failed to comply with The Long Term Care Homes Program Manual Standards and Criteria.

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

Findings:

1. An identified resident had a rapid and significant deterioration in physical condition from admission in 2009 to transfer to hospital in 2010. New onset swallowing difficulties that resulted in at least 3 bouts of aspiration pneumonia, seizure disorder, 10 falls, changes in strength, mobility and tolerance levels that added to the residents risk for falls. No reassessment of this change in health status was conducted by staff during this time to determine required care needs of the resident as a result.
2. Quarterly assessment completed in 2010, did not include a reassessment of changes to the resident's condition. One fall and 2 bouts of pneumonia were noted during this time period without any further assessment of these risk areas or changes to the plan of care as a result.

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WN #4: The Licensee has failed to comply with **The Long Term Care Homes Program Manual Standards and Criteria.**

Criteria M1.6: Current policies and procedures, consistent with the Ministry policies and directives, shall be in place to guide the management and service delivery of each program and service.

Findings:

1. During interview with the Director of Care, it was determined that the home currently has no formal falls prevention program to follow. Staff discuss each case individually with the Director of Care to determine the course of action.
2. No formal education has been conducted with front line staff related to falls prevention.
3. No education related to falls prevention was presented to staff as a result of this resident's recurring falls in the home.

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WN#5: The Licensee has failed to comply with **The Long Term Care Homes Program Manual Standards and Criteria.**

Criteria B3.17: Risks to each resident's health and safety shall be identified and addressed in ways that consider his/her choice, freedom of movement, dignity and respect, in keeping with other resident's rights.

Findings:

1. Risks related to falls, seizures, choking, restraints, severe cognitive behaviours resulting in unsafe wandering were not identified or addressed in ways that reduced/mitigated risk to an identified residents health and safety.
2. An identified resident had a rapid and significant deterioration in physical condition from admission in 2009 to transfer to hospital in 2010. New onset swallowing difficulties that resulted in at least 3 bouts of aspiration pneumonia, seizure disorder, 10 falls, changes in strength, mobility and tolerance levels that added to the residents risk for falls. No reassessment of this change in health status was conducted by staff during this time to determine required care needs of the resident as a result.

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WN#6: The Licensee has failed to comply with **The Long Term Care Homes Program Manual Standards and Criteria.**
Criteria B2.4: Each residents plan of care shall reflect his/her current strengths, abilities, preferences, needs, goals, safety/security risks, and decisions including advance health care directives provided by the resident or any substitute decisions provided by the lawfully authorized person. The plan of care shall give clear direction to staff providing care.

Findings:

1. An identified resident was admitted to the Wellington Nursing home in 2009. Information available to staff on admission indicated that this resident had a history of falls as well as significant behaviours that impacted the risk for falls. The behaviour was noted to continue in the home after admission. A falls risk assessment tool was completed on December 2009 with a score of 32 (moderate risk for falls). A second risk assessment tool was completed on March 2010 with a score of 37 (high risk for falls). The plan of care reviewed during inspection on August 24, 25, 2010 still showed the resident as a moderate risk for falls.
2. Written plan of care problem statement for falls included that this resident was ambulatory for hours without breaks, would fatigue, and states this as risk for falls. Progress notes show that staff were using a wheelchair with a seatbelt occasionally to have the resident sit and rest, as the resident would not otherwise sit. The registered staff were to assess when and how long this intervention was to be utilized. There were no clear directions for staff on parameters of use related to this intervention.
3. An identified resident was diagnosed with a Seizure disorder in 2010 and started on medication to control this disorder. No written plan of care related to seizure disorder was found for this resident.
4. An identified resident had at least 3 documented episodes of pneumonia, querying aspiration pneumonia. Speech Language Pathology was called to assess residents swallowing function in 2010. Recommendations were left for staff to implement. These recommendations were not added to the written plan of care to provide direction to staff.
5. An identified resident was noted in the progress notes to frequently climb out of bed. This risk was not identified on the written plan of care and had no interventions or direction to staff to prevent or mitigate

this risk for falls. Staff were noted to be using a bed alarm as documented in the progress notes; this intervention was not found on the written plan of care.

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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 for the purpose of publication Letter resigned Aug 5/11
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).