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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 6, 13, 16, 26, Sep 6, Oct 7, 2011	2011_027192_0018	Other

Licensee/Titulaire de permis

BENEVOLENT SOCIETY "HEIDEHOF" FOR THE CARE OF THE AGED
600 Lake Street, St. Catharines, ON, L2N-4J4

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

HEIDEHOF LONG TERM CARE HOME
600 Lake Street, St. Catharines, ON, L2N-4J4

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 an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, and Personal Support Workers related to H-00415.

During the course of the inspection, the inspector(s) reviewed medical records, policy and procedure and observed care provided.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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. A specified resident sustained 21 falls. The plan of care reflects that the "resident has frequent falls but usually isn't injured." Interventions within the plan of care have not been effective in preventing falls and the plan of care has not been revised in spite of ongoing falls sustained.

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 residents are reassessed and the plan of care reviewed and revised at least every six months and at any other time when, care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. A specified resident was observed on May 6, 2011 with a front fastening seat belt in use, no documentation related to alternatives tried was noted in the medical record.
2. A specified resident was observed with a rear fastening table top and a front fastening seat belt. A review of the medical record could not establish alternatives to restraint that where trialed for this resident.
3. A specified resident was observed with a rear fastening seat belt. The medical record for the resident was reviewed and no documentation was present that indicates alternatives to restraint were used prior to applying a seat belt.
4. Staff of the home were noted to have applied restraining devices for which there is no written order from a physician or registered nurse in the extended class.
a. A specified resident was noted with a rear fastening table top and a front fastening seat belt. No order for restraint was noted on the Quarterly Medication Review dated April 28, 2011, or elsewhere in the medical record.
b. A specified resident was observed sitting in a wheelchair in the lounge with a rear fastening seat belt in place. There is no order in the medical record for the restraint used for this resident.
5. Residents of the home, noted to be in restraint, were not released from the restraint at least once every two hours.
Four residents were observed between 0935 and 1150 on May 6, 2011 in a lounge with restraints in place. Three of four residents were not repositioned and did not have their restraint removed during the identified time frame.
A specified resident was observed in a lounge between 0935 and 1150 sitting in a wheelchair with a rear fastening seat belt. At 1150 the resident was transported by staff to the dining room for lunch. The resident was not repositioned or her restraint released during the observation period or during lunch.
Personal Support Workers interviewed indicated that they are responsible to check residents in restraint to ensure that the restraint is not too tight or too loose and that the restraint is in the right position every two hours.
6. Residents of the home do not have their condition reassessed and the effectiveness of the restraining evaluated by a physician, a registered nurse in the extended class or a member of the registered nursing staff, at least every eight hours and at any other time when necessary based on the residents condition or circumstances.
a. A specified resident was observed in a lounge with a rear fastening seat belt in place. There is a Physical Restraint Monitoring Record for a rear fastening seat belt but it does not include signatures of registered staff indicating that the resident had been reassessed or the effectiveness of the restraint evaluated.
b. A specified resident was observed with a rear fastening table top and a front fastening seat belt. The Physical Restraint Monitoring Record does not include signatures from registered staff indicating that the residents condition had been assessed or the restraint use evaluated.
c. Interview with the Registered Practical Nurse confirms that registered staff are not documenting their assessment of the resident and evaluation of the restraint use on the Physical Restraint Monitoring Record.
d. Interview with the Administrator and Director of Care confirm that the form used at the home does not provide space for registered staff to sign that resident assessment and restraint evaluation are completed at least every eight hours, or at any other time when necessary based on the resident's condition. It is also confirmed that this information is not recorded elsewhere in the medical record.
7. A specified group of residents did not have consent for restraints currently in use:
a. A specified resident was noted to be sitting in a wheelchair with a rear fastening seat belt. The plan of care indicates that bed rails are also used for this resident. No signed consent from the resident or the power of attorney is present on the medical record for the use of a rear fastening seat belt or bed rails.
b. A specified resident was observed with a rear fastening table top and a front fastening seat belt. No signed consent from the resident or her power of attorney was present on the medical record.
The registered staff member interviewed did identify that consent is required for restraint. The staff member was unable to locate consents in the medical records for the residents reviewed.

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 every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
What alternatives were considered and why those alternatives were inappropriate, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following subsections:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The plan of care for some residents does not include interdisciplinary assessment of health conditions and risk of falls.
a. A specified resident sustained multiple falls resulting in injury, no interventions related to preventing falls or minimizing injury were identified in the plan of care. The resident fell, sustaining an injury, the resident was assessed by staff and taken to hospital for further assessment. The resident fell while ambulating from the dining room to the bed room, sustaining a bruises and pain. The resident fell in the hallway after a loss of balance.
b. A specified resident sustained approximately 21 recorded falls within a specified time frame. No interventions have been established to reduce the number of falls and prevent injury.

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following aspects to the resident: Health conditions, including allergies, pain, risk of falls and other special needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following subsections:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. A specified resident was observed with a front fastening seat belt. No consent for restraint was available in the medical record. No order is noted on the medical record.
A specified resident was noted to require the use of a table top. No order was available in the medical record.
A specified resident has documentation on the physician's notes of a request for rear fastening seat belt. The resident was observed with a rear fastening seat belt. There is no order for restraint.
3. A specified resident was observed with a front fastening seat belt. No alternatives to restraint are documented.
A specified resident was observed with a rear fastening seat belt. There is no documentation in the medical record of alternatives to restraint.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. A specified resident had no falls assessment using a clinically appropriate assessment tool completed after a second fall.
A specified resident sustained 21 falls during a specified period of time. No falls assessment using a clinically appropriate assessment tool have been completed.

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 a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for a falls, to be implemented voluntarily.

Issued on this 16th day of September, 2011

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