Ontario

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

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
Jan 20, 2014	2013_246196_0012	S-000503-12,S-000707-12	Critical Incident System

Licensee/Titulaire de permis

Southbridge Capital CBH #2 LP

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

BIRCHWOOD TERRACE
237 Lakeview Drive, R. R. #1, KENORA, ON, P9N-4J7

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 12, 13, 14, 15, 16, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Residents and family members.

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident care areas, observed the provision of care and services to residents, observed the staff to resident interactions, reviewed the health care records for several residents and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

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:
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:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

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:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. On a particular day in August 2013, resident #011 was observed sitting in a wheelchair with a seat belt restraint in place. Staff member #102 confirmed with the inspector that this was a restraint in place to prevent falls as the resident had a recent fall and injury. The health care record for resident #011 was reviewed and included a physician's order and a consent from the Power of Attorney (POA). The restraint monitoring record for the month of August 2013, specifically August 9 through to August 13, 2013 was reviewed and there were no initials of the registered staff to acknowledge the reassessment and the effectiveness of the restraining of resident #011 over this five day period. Staff member #102 confirmed to the inspector that the resident was up in the tilt chair with the seat belt restraint in place over the five days and that the documentation is not complete.

The licensee failed to ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act: 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. [s. 110. (2) 6.]

2. On a particular day in August 2013, resident #011 was observed sitting in a wheelchair with a seat belt restraint in place. The restraint monitoring record for the month of August 2013, specifically August 9 through to August 13, 2013 was reviewed. Over these five day shifts, there are no initials to identify the person who applied the restraint on resident #011 and the time of application.

The licensee failed to 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: 5. The person who applied the device and the time of application. [s. 110. (7) 5.]

3. The restraint record for resident #011 for the time period of August 9 to 13, 2013 did not include documentation of the resident's response to the use of a physical device to restrain.

The licensee failed to 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: 6. All assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

4. The restraint record for resident #011 for the time period of August 9 to 13, 2013, did not contain documentation of every release of the physical restraint device and all repositioning.

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: 7. Every release of the device and all repositioning. [s. 110. (7) 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 that ensures that the resident's condition is reassessed and the effectiveness of the restraining evaluated by 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, that the person who applied the device and the time of application is documented, all assessment, reassessment and monitoring, including the resident's response and every release of the device and all repositioning is documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The care plan for resident #005 identified the method of transfer to be "transfer as per logo - one person with transfer belt". The assessment for lifts and transfers was reviewed and identified that for all shifts the resident to be "one person assist with transfer belt". On a particular day in August 2013, staff member #104 was observed to transfer resident #005 from the bed into a wheelchair by placing their arm under the resident's arm and pivoting. Staff member #104 was questioned about the transfer logo above the resident's bed and reported that they don't work very often on this floor and that a transfer belt should have been used.

The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. An interview was conducted with staff member #103 and it was reported to the inspector that the Ativan prn (as needed) and other controlled medications are stored in the locked box in the medication carts, are counted and are double locked. It was determined, after discussion with staff member #103 that those residents that receive regular dosing of these controlled medications have them supplied in the medication rolls, and these are not counted nor are they double locked.

Resident #008, #009, #010 and #011 were all noted to have controlled medications in the medication rolls and they are not counted nor under a double lock.

Policy titled "Controlled Drugs" #LTC-G-30 with review date of December 2010 was reviewed by the inspector. This policy included in it's procedure, "All stock controlled drugs must be kept under double lock separate from all other medications", but did not refer to controlled drugs that are not stock supply. In addition, the policy stated "Controlled drugs are counted at the end of each shift in accordance with the policy of each individual home using the Controlled Drug Count Sheet" and it had been identified that counting of these regularly dosed medications was not being done.

The written policies and protocols must be, developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; [s. 114. (3) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

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Issued on this 20th day of January, 2014

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

Lauren Senhuber #196

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Staff member #103 reported to the inspector that the Ativan prn (as needed) and other controlled medications are stored in the locked box in the medication carts, they are counted and are double locked. It was determined, after discussion with staff member #103 that those residents that receive regular dosing of these controlled medications have them supplied in the medication rolls and they are not double locked.
This included resident #008, #009, #010, and #011 who were observed by the inspector to have controlled substances, specifically medication, in their medication rolls and they are not double locked.

The licensee failed to ensure that, controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]