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

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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
Oct 12, 13, 19, 20, 21, 24, 2011	2011_034117_0030	Complaint

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch, 275 Perrier Avenue, OTTAWA, ON, K1L-5C6

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

CARLETON LODGE
55 LODGE ROAD, R. R. #2, NEPEAN, ON, K2C-3H1

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), RAI Coodinator, Rehab Assistant, to three Registered Nurses (RN), to a Registered Practical Nurse (RPN), to several Personal Support Workers (PSW), to a resident and to a resident family member.

During the course of the inspection, the inspector(s) reviewed the health care record of a resident; examined a resident room; examined a Broda chair, lap belt and rear closure lap tray and a tilt wheelchair with lap belt and lap tray.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

Pain

Responsive Behaviours

Skin and Wound Care

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 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).

Findings/Faits saillants :

1. A resident is identified as being at high risk for falls. Personal Assistance Safety Devices (PASD) were applied and in use for the resident since late September 2011.

On an identified date in September 2011, the resident removed the applied Broda chair lap belt and lap tray PASDs, and slid to cushioned foot rest of the Broda chair. No injuries were noted.

On an identified date in October 2011, the resident removed the applied Broda chair lap belt and lap tray PASDs, and fell on the floor. The resident sustained injuries.

On an identified date in October 2011, the resident's attending physician ordered a rear closure restraint. The resident's POA gave consent for the use and application of the rear closure restraint. As per interviewed unit RN, a lap tray with rear closure restraint was applied to the resident's Broda chair that same day.

As per progress notes, during that evening, the resident was seated in a tilt wheelchair with a lap belt and lap tray with no rear closure restraint. The resident removed the lap belt and lap tray, and was found on the floor by one of his/her family members. No injuries noted.

After the fall, the resident was repositioned in the same tilt wheelchair with lap belt and lap tray with no rear closure restraint. The resident removed the lap belt and lap tray during that night. The resident was attempting to get out of chair when nursing staff intervened. The resident did not fall. No injuries noted.

As per interviews with unit RN and PSWs, the resident has been using the Broda chair with rear closure restraint as ordered since the identified evening and night time falls.

The licensee has failed to ensure that staff apply the ordered rear closure restraint on an identified evening and night. [section 110 (2) (1)]

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 to ensure that staff continue to apply rear closure restraints that have been ordered by the physician, to be implemented voluntarily.

WN #2: 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. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The Long-Term Care (LTC) home's Fall Prevention program, approved on February 14, 2011, indicates that the following equipment / supplies are to be available for potential use: bed rails, high-low beds, restraints, mattresses (floor pads).

The LTC home's Least Restraint program, approved in June 2007 and revised in January 2011 indicates that full bed rails, seat belts secured in back and table tops can be used as restraints.

The home's DOC documented in resident care conference notes held on an identified day, that the home did place a high-low bed in the resident's room as a fall prevention intervention but that floor mats were not in place as the home did not have them. The note indicates that the home was waiting for the mats arrival to put in place as an adjunct fall prevention interventions to the use of the high-low bed, in the resident's room.

Meetings held with the Administrator, DOC, unit RN, and several PSW confirm that the home has not had full bed rails on site for several years. It was also confirmed that the home does not have floor mats on site as fall prevention interventions. Floor mats need to be ordered on an as needed basis.

It is noted that floor mattresses were observed to be in the resident's room at the time of this inspection. It is also noted that full bed rails were ordered after this inspection.

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 to ensure that equipment, supplies, devices and assistive aids, such as full bed rails and floor mattresses, are readily available at the home, to be implemented voluntarily.

Issued on this 24th day of October, 2011

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