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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Mar 18, 2013	2013_179103_0012	O-001888-12	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PORT HOPE)
20 HOPE STREET SOUTH, PORT HOPE, ON, L1A-2M8

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): March 14-15, 2013

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses, Registered Nurses, Restorative Care Aide and the Director of Care.

During the course of the inspection, the inspector(s) did a walk through of the resident unit and reviewed the resident health care record.

The following Inspection Protocols were used during this inspection:

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Falls Prevention

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007 s. 6(1)(c) whereby the plan of care for a resident at risk for falls did not provide clear direction to staff.

Resident #1 was admitted to the home on an identified date, was known to be unsteady on his/her feet and had been identified as at risk for falls on the admission assessment provided to the home from the Community Care Access Centre (CCAC).

From the time of the resident's admission to an identified date, Resident #1 sustained one fall after climbing out of his/her bed and had five subsequent unsafe transfers documented at which time a progress note indicated to leave one bedrail down. Resident #1 continued to climb out of bed and a bed alarm was then requested.

On an identified date, Resident #1 attempted to self transfer into the wheelchair from the bed and sustained an injury that required a transfer to hospital. At the time of the unsafe self transfer, the bed alarm did not activate. The Director of Care was interviewed and was unsure whether the alarm was not working or if the staff member had failed to ensure it was working when the resident was assisted to bed that evening.

Resident #1's plan of care in effect at the time of the injury, identified the resident as a medium fall risk on the Resident Assessment Protocol (RAP) and as a very high risk on a Fall assessment tool. The care plan available to staff did not include strategies to reduce the risk of falls or unsafe self transfers and there was no indication that a bed alarm was being used. The care plan indicated bed rails were being used for bed mobility but had no direction as to the number of rails to be used. The care plan's only direction in regards to transfers was to "monitor resident for unsafe transfers." [s. 6. (1) (c)]

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 residents identified at risk for falls have a written plan of care that provides clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 50(2)(b)(iv) whereby a resident exhibiting altered skin integrity was not reassessed at least weekly by a member of the registered nursing staff.

Resident #1 was assessed for a deteriorating wound on an identified date. Over a period of four months, the wound was not assessed on a weekly basis by a member of the registered nursing staff.

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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 residents exhibiting altered skin integrity will receive weekly assessments by a member of the registered nursing staff, to be implemented voluntarily.

Issued on this 18th day of March, 2013

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