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

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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
Jun 20, 2013	2013_200148_0021	O-000386-13	Complaint

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 (ALEXANDRIA)
92 CENTRE STREET, ALEXANDRIA, ON, K0C-1A0

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 30 and 31, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Resident Care Coordinator, Registered Nursing staff and Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed resident health record including plan of care, assessment and monitoring documentation. In addition, policies relating to medication administration and restraints were reviewed and a meal observation was conducted.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Dining Observation

Falls Prevention

Minimizing of Restraining

Personal Support Services

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.)	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 LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

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:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

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:
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. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O., 2007, c.8, s.31 (2) 4., in that the licensee did not ensure that the restraining of a resident by a physical device, that was included in the resident's plan of care, included an order by the physician or registered nurse in the extended class.

The admission physician orders for an identified resident indicated the use of a physical restraint at mealtimes and as needed.

According to a Physician's Order Review on a specified date, the physician order related to the above noted restraint was not transcribed. The Physician's Order Review discontinues all previous physician orders.

Interviews with Registered Nursing staff members #102 and #103, indicated that a restraint was used for the identified resident for behaviours and due to a risk of falls. Both Registered Staff members reported to Inspector #148 that this restraint was used from the date of admission to the resident's discharge. As reported by the Registered Nursing staff members and as confirmed by the Restraint Monitoring Records, the identified resident was restrained frequently.

The restraint plan of care did not include an order by the physician or a registered nurse in the extended class. [s. 31. (2) 4.]

2. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 31 (2) 5., in that the licensee did not ensure that the restraint plan of care included the consent of the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

On a specified date the physician ordered a physical restraint for an identified resident to prevent injury to self and others.

Restraint Monitoring records for the identified resident indicated the above physician order was implemented. Registered Nursing Staff members #102 and #103 both reported to Inspector #148 that the above physician order for a restraint was provided to the identified resident.

A document in the health care record, entitled Consent to use Physical or Chemical Restraints, indicated the use of a physical restraint. The consent document was

signed by the physician on a specified date. The consent of the resident's Substituted Decision-maker (SDM), who has authority to give consent, was not obtained for the use of the physical restraint.

Information obtained by the SDM and documentation in the resident's health care record support that the SDM did not give consent to the use the most recent physician order for a restraint. [s. 31. (2) 5.]

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 the plan of care related to the restraining of a resident by a physical device includes consent from the resident or Substitute Decision Maker and a current physician's order for the restraint, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to comply with LTHCA 2007, S.O. 2007, c.8, s.6(7), in that the licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for an identified resident indicated that a bed alarm is to be used when the resident is in bed to prevent self transfer and notify staff when the resident is getting up.

At a specified time on a specified date, an identified resident fell out of bed, no apparent physical injury was noted by the registered nursing staff assessment.

A document entitled, Resident Incident Report completed on the same date as the fall, indicates that Staff member #101 heard a loud yell and boom from the identified resident's room and on approach found the resident on the floor. The Resident Incident Report indicates that the intervention to prevent recurrence is to ensure that the bed alarm is plugged in.

Staff member #101 was interviewed in relation to the fall. Staff member #101 reported to Inspector #148 that she did not hear the bed alarm trigger and on inspection of the room the staff member found that the bed alarm was unplugged and therefore not functional.

The plan of care, as it relates to the use of a bed alarm was not provided to an identified resident on a specified date. [s. 6. (7)]

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Issued on this 20th day of June, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Amanda Nixon RD LTCH Inspector