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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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 24, 25, 26, 27, 28, 2011; Jan 11, 12, 23, 2012	2011_056158_0015	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHWESTERN ONTARIO INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, reviewed the home's "Safe Lifting with Care" policy, the home's "Medication Administration" policy, the home's July 2010 Falls Prevention and Management policy, the home's September 2010 Responsive Behaviour Policy, the home's restraint policy, the home's critical incident reports sent to the Ministry of Health and Long Term Care and observed staff providing resident care.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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. (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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 did not ensure that the plan of care set out clear directions to staff and others who provide direct care to a resident.
A resident was diagnosed with a behavioural disorder by the doctor. The doctor ordered two anti-psychotics and an anxiolytic to manage agitation and yelling.
On October 27/11 at 1715h, the inspector observed that the resident who was in the dining room was yelling loudly and consistently. The resident was brought to the resident's room by a PSW who then closed the resident's door leaving the door ajar approximately one foot. The PSW expressed to the inspector and to another PSW that this was the only thing that can be done to manage the resident's yelling.
The resident's plan of care identified that interventions for the yelling behaviour related to the resident's ear disease were to encourage the resident not to yell and to bring the resident into the dining room when ready to be served the meal.
The management of the resident's yelling related to the resident's behavioural disorder was not included nor were clear directions set out in the plan of care to manage the resident's behaviour.
[LTCHA 2007, S.O. 2007, s. 6(1)(c)]
2. 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.
A resident's plan of care identified that the resident has cognitive loss, unsteady gait and self transfers. Fall prevention interventions, such as, "ensure the resident wears a front seat belt while up in the wheel chair", and "is to wear a portable personal alarm which is clipped to mid back area of the chair " was set out in the resident's plan of care.
On October 24/11 at 1700h, the inspector observed that the resident's portable personal alarm was clipped to the lower left side of the wheel chair and within the resident's reach. The wheel chair's seat belt was buckled, however, it was observed to lay loosely on the resident's upper thighs midway to the resident's knees. The resident's care as set out in the plan of care was not provided.
[LTCHA 2007, S.O. 2007, s. 6(7)]
3. 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.
A resident had an open wound which was healing. The resident's plan of care identified that the resident was to be repositioned every two hours. The inspector observed that the resident remained seated in the wheel chair on October 24/11 from 1530h to 1740h and on October 25/11 from 1500h to 1730h without being repositioned.
The resident's care as set out in the plan of care was not provided as specified in the plan.
[LTCHA 2007, S.O. 2007, s. 6(7)]
4. The licensee did not ensure that the care set out in the plan of care was provided to a resident as specified in the plan.
It is documented in a resident's progress notes that the resident sustained two skin tears after the resident had fallen out of bed. The resident's portable personal alarm was not in place.
The resident's plan of care states " ensure portable personal alarm is applied while in bed and wheel chair at all times" and "ensure the portable personal alarm is in its covering to ensure it functions properly".
The resident's care as set out in the plan of care was not provided as specified in the plan.
[LTCHA 2007, S.O. 2007, s. 6(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 ensuring that clear direction is provided to staff and others who provide care to the residents and ensuring that the residents are provided with the care set out in the their plan of care, 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 licensee did not ensure that the staff used safe transferring and positioning devices or techniques when assisting a resident.
The staff found a resident on the floor in front of the wheel chair with a loop of the transfer sling the resident was sitting on wrapped around the resident's left ankle.
The resident's progress notes identified that there were reported episodes of self transferring on four other occasions. There were three documented falls.
The resident's plan of care identified the resident as a high risk to fall.
The resident's plan of care identified that the resident required two staffs' assistance with transferring from the wheel chair to the bed using a medium sling and the non weight bearing mechanical lift. The plan of care did not identify that the sling was to remain under the resident when sitting in the wheel chair.
On October 25/11 at 1230h, the inspector observed the resident fidgeting in the wheel chair while the resident sat in the dining room. The resident was sitting on the transfer sling, which was askew with the straps reaching over the side of the wheel chair to the bottom of the left foot pedal. The wheel chair's seat belt was not fastened.
Safe positioning techniques were not used.
[O. Reg. 79/10, s. 36]

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 staff use safe transferring and positioning techniques, especially with the use of transfer slings when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following subsections:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(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;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The home did not ensure that a resident with altered skin integrity received interventions to promote healing.
The inspector observed that the transfer sling was not evenly placed under a resident when the resident was sitting in the wheel chair on October 24/11 from 1530h to 1745h and on October 25/11 from 1500h to 1730h.
The home's "Safe Lifting with Care" policy related to mechanical lifts identified that "two staff members are to remove the sling from underneath the resident" unless the resident's care plan stipulates that the sling can be left under the resident if it is "crease free and positioned properly".
The resident's plan of care identified that the resident had an open wound. The plan of care identified that the resident is transferred from the bed to the wheel chair by two staff with a non-weight bearing mechanical lift and a large size sling. There is no mention that the sling can remain under the resident when the resident is sitting in the wheel chair.
The resident's plan of care identified that the resident was to be repositioned every two hours. The inspector observed that the resident remained seated in the wheel chair from on October 24/11 from 1530h to 1745h and on October 25/11 from 1500h to 1730h without being repositioned.
Interventions to promote the healing of the resident's open wound were not provided.
[O. Reg. 79/10, s. 50 (2)(b)(ii)]

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 with impaired skin integrity receive interventions that promote healing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. A drug that was not prescribed for the resident was used and administered to a resident.
The doctor was called in to see a resident and the resident was diagnosed with a behavioural disorder. An order for drugs to manage the resident's behaviour was given by the doctor.
A RPN documented in the resident's progress notes that one of the anti-psychotic drugs administered to the resident was "borrowed" from another resident as the resident's drug was not received from the pharmacy. The direction to "borrow" the drug was given by the another RPN.
[O. Reg. 79/10, s. 131 (1)]
2. The licensee did not ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.
The doctor was called in to see a resident displaying behaviours. An anti-psychotic drug was ordered by the doctor to be administered in the evening, however, the drug was not delivered to the home that evening and subsequently, the drug was not administered as prescribed. Although the drug was delivered the next day, the resident's Electronic Medication Administration Record (E-MAR) identified that the drug was not administered as prescribed to the resident that day either.
The anti-psychotic drug that was ordered was not administered to the resident in accordance with the direction for use specified by the prescriber.
[O. Reg. 79/10, s. 131 (2)]

Issued on this 23rd day of January, 2012

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