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
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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 13, 14, 16, 19, 20, 21, 2012	2012_196157_0007	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE LAKEFIELD
19 FRASER STREET, P. O. BOX 910, LAKEFIELD, ON, K0L-2H0

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

PATRICIA POWERS (157)

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 Administrator, a Registered Nurse, a Registered Practical Nurse, two Personal Support Workers and three residents.

During the course of the inspection, the inspector(s) reviewed the clinical health records of six residents, reviewed five critical incident reports, observed care practices, observed staff interactions with residents, reviewed the home's policies and procedures related to the use of Mechanical Lifts, Resident Abuse and Neglect, Falls Management and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set out clear direction to staff and others who provide direct care to the resident:

Progress notes for resident #05 indicate that:
- Resident #05 was found in the room of resident #07 on two occasions, making physical contact with the resident. Resident #07 indicated by words and actions that this contact was not welcome.
There is no direction in the plan of care for resident #05 related to this behaviour or interventions to manage this behaviour in order to ensure the safety of resident #07. Staff interviewed are not aware of how these behaviours should be managed and they state that they put their own interventions in place in an attempt to keep resident #07 safe. [s.6.(1)(c)]

MDS Assessments for resident #05 identify behaviours requiring interventions. There is no direction in the plan of care related to these behaviours or planned interventions to manage them.[s.6.(1)(c)]

Progress notes indicate that resident #06 wanders the halls and often wanders into the room of resident #05. This angers resident #05 causing agitation and the potential for the resident to be physically aggressive. There is no direction in the plan of care related to this risk or planned interventions required to prevent the risk to resident safety. [s.6.(1)(c)]

2. Progress notes indicate that resident #03 experienced falls on 4 dates. The most recent plan of care does not provide written direction to staff and others who provide direct care to the resident related to interventions for fall prevention. [s.6.(1)(c)] (Log #002864-11)

3. The most current plan of care for resident #02 does not provide direction to staff and others who provide direct care to the resident related to:
- the use of a restraint
- a physician's order for post fall care needs.
- fall prevention interventions [s.6.(1)(c)](Log #000841-12)

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 written plan of care sets out clear direction to staff and others who provide direct care to the resident related to responsive behaviours and falls prevention, 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 failed to ensure that staff use safe transferring techniques when assisting residents:

Critical Incident report states that a PSW improperly transferred resident #01, causing the resident to suffer pain and injury. The resident was not transferred using safe techniques resulting in pain and injury. [s.36] (Log #000484-12)

2. Progress notes indicate that a staff member used a mechanical lift to transfer resident #04 and the resident reported being injured during the transfer. The staff failed to adhere to facility policy, Safe Lifting and Care Program, "Mechanical Lifts, 01-02 revised May 2009, which states that "Two trained staff are required at all times when performing a mechanical lift", by using a mechanical lift to transfer the resident without the assistance of another staff member. [s.36] (Log #000872-12)

WN #3: 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. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Progress notes indicate that resident #04 reported being injured during a transfer. The staff did not report the incident to registered nursing staff at the time the incident occurred and there was no evidence that a post fall assessment was conducted.[s.49(2)] (Log #000872-12)

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. Progress notes indicate that:
- Resident #05 was found in resident #07's room on two occasions, making physical contact with the resident. Resident #07 indicated by words and actions that this contact was not welcome.
Police were not notified of a suspected, witnessed incident of abuse. [s.98]

Issued on this 21st day of November, 2012

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