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
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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
Jan 7, 2014	2013_246196_0015	S-000355-13	Other

Licensee/Titulaire de permis

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET, P.O. BOX 190, HORNEPAYNE, ON, P0M-1Z0

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

HORNEPAYNE COMMUNITY HOSPITAL
278 FRONT STREET, P.O. BOX 190, HORNEPAYNE, ON, P0M-1Z0

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

LAUREN TENHUNEN (196)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): October 17, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Recreation Staff member, RAI Coordinator, Residents and family members

During the course of the inspection, the inspector(s) conducted a walk through tour of all resident care areas, observed the provision of care and services to residents, observed the interactions between staff members and residents, reviewed the health care records for several residents, reviewed various policies and procedures

The following Inspection Protocols were used during this inspection:
Residents' Council

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The current restraint policy titled "Restraints - Long Term Care" with operational date of December 1, 2006 was provided by staff members #101 and #103 to the inspector upon request. This policy was reviewed for the required information and did not comply with the requirements as provided for in the regulations. Specifically, the policy failed to include the types of physical devices permitted to be used, how consent to the use of physical devices is obtained and documented, alternatives to the use of physical devices, how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation.

The licensee's policy failed to comply with such requirements as may be provided for in the regulations. [s. 29. (2)]

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 that ensures the licensee's policy to minimize restraining of residents complies, with the requirements in the regulations, to be implemented voluntarily.

WN #2: 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:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. Resident #004 was observed in a physical device to restrain. The health care record for this resident included a physician's order for the use of a physical device to restrain and noted it's use in the kardex and care plan.

Staff member #102 reported that there was no documentation regarding the use of restraint for resident #004, therefore there was no record of the person who applied the device and the time of the application. Staff member #103 provided a blank copy of "LTC restraint/safety record" and stated "this may need modification and will begin using this form immediately".

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, the person who applied the device and the time of application. [s. 110. (7) 5.]

2. Staff member #102 reported that there was no documentation regarding the use of restraint for resident #004, therefore there was no documentation to include all assessment, reassessment and monitoring, including the resident's response.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented all assessment, reassessment and monitoring, including the resident's response. [s. 110. (7) 6.]

3. Staff member #102 reported that there was no documentation regarding the use of restraint for resident #004, therefore there was no documentation to include every release of the device and all repositioning.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, every release of the device and all repositioning. [s. 110. (7) 7.]

4. Staff member #102 reported that there was no documentation regarding the use of restraint for resident #004, therefore there was no documentation to include the removal or discontinuance of the device, including time of removal or discontinuance

and the post-restraining care.

The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. [s. 110. (7) 8.]

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 that ensures that every use of a physical device to restrain a resident under section 31 of the Act is documented and, includes the person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. On October 17, 2013, the stove in the common dining room was observed to have three of four control knobs missing. The remaining control knob was within reach of residents and was tested and found to turn the element on.

On October 17, 2013 at 1050hrs, resident #002 was observed sitting on a gliderswing at the end of the corridor. The resident was attempting to get up off the seat and stand by themselves and had great difficulty as the glider kept going back and forth. This type of swing is usually seen outdoors. This potential for fall was brought to the attention of staff member #103 and they had thought the swing was locked and was not able to glide back and forth.

The licensee failed to ensure that the home is a safe and secure environment for its residents. [s. 5.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. During the initial tour of the home on October 17, 2013, a cupboard outside of the staff washroom, accessible to residents, was unlocked and contained a bottle of "Accel TB" disinfectant.

The licensee failed to ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. [s. 91.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Resident #003 was observed to have a container of topical Voltaren medication at the bedside. This had been ordered by the physician but did not have an order to have it left at the bedside. An interview was conducted with staff member #104 and it was reported that "they must have a Dr.'s order to have eye drops and creams/gels at the bedside".

The licensee failed to ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)]

Issued on this 8th day of January, 2014

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

Lauren Lenhuren #196.