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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 21, Jul 3, 6, Sep 7, 2012	2012_027192_0035	Critical Incident

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

KILEAN LODGE
83 MAIN STREET EAST, GRIMSBY, ON, L3M-1N6

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

DEBORA SAVILLE (192)

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, Director of Care, Registered Nurses, Personal Support Workers, and the Resident Assessment Instrument (RAI) Co-ordinator related to H-000129-12.

During the course of the inspection, the inspector(s) observed the provision of care, reviewed medical records and policy and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Minimizing of Restraining

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 plan of care sets out clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

a) Resident 004 is identified in the plan of care to require a broda chair with table top for positioning. Resident 004 was observed in 2012 in a tilt wheelchair with tabletop. Kardex accessible to all staff does not include the use of a tilt chair with table top, but does include the use of two full bed rails, not included in the plan of care. Interview confirms that resident 004 uses a tilt wheelchair with table top and two full bed rails when in bed.
Sources of information related to the care of resident 004 provide conflicting information for staff and others who provide direct care to the resident.

b) Resident 005 was observed reclined in a tilt wheelchair in 2012. The plan of care indicates use of a wheelchair, but does not provide direction to staff and others who provide direct care to the resident related to the use of a tilt wheelchair which has the potential to have restraining properties.

c) Sources of information related to the care of resident 006 provide conflicting information for staff and others who provide direct care to the resident related to the use of a bed alarm vs a chair alarm.

WN #2: 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 subsections:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

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:
1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
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.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraint plan of care includes the consent of the resident or if the resident is incapable, by the Substitute Decision Maker. [s. 31. (2) 5]

a) Resident 001 was observed restrained in 2012. Interview confirms that resident 001 uses identified types of restraint.

b) Consent for the use of all types of restraint currently in use is not included in the plan of care. Interview confirms that consent had not been obtained for all restraints.

2. The licensee failed to ensure that a restraint by physical device is included in the plan of care. [s. 31. (1)]

a) Resident 001 was observed in 2012 to be restrained. Interview confirms the use of restraint.

b) The plan of care available to staff on a specified date in 2012 did not include the use of restraints observed in used. It was noted that the plan of care was updated to include one type of restraint, but the plan of care available to staff on a specified date in 2012 does not include the use of a second type of restraint.

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 restraint plan of care includes the consent of the resident or if the resident is incapable, by the Substitute Decision Maker, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following subsections:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD 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.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Services Device(PASD) under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied: 4. The use of the PASD 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. [s. 33 (4) 4].

Documentation review and interview confirm that the following residents (002, 005, 006, 007 and 008) are using PASD's without evidence of consent within the medical record.

Resident 004 has signed consent for the use of specified PASD's. Interview and record review confirm the resident uses different PASD's than identified in the signed consent. No consent for the use of PASD's currently in use, is evident on the medical record.

WN #4: 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 subsections:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

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:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
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. The licensee failed to ensure that the resident's condition has been reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances [r. 110. (2) 6]

a) Resident 001 was confirmed through interview and documentation review to require the use of a restraint.

b) Restraint documentation was reviewed for two months in 2012. It was noted that for one month in 2012 the documentation related to reassessment and effectiveness of restraints in use was not completed on 10 shifts (days and evenings). For the second month in 2012 documentation related to reassessment and effectiveness of restraints in use was not completed on 18 shifts.

2. The licensee failed to ensure that restraint documentation includes every release of the device and repositioning. [r. 110. (7) 7.]

a) Resident 001 was identified through documentation review and interview to require the use of restraints.

b) Documentation completed for resident 001 for three identified months in 2012 does not consistently indicate when restraining devices applied were removed and that the resident was repositioned. For one month in 2012 - for 17 of 31 evenings there is no record of removal or repositioning of the resident. In the second identified month in 2012 - for 11 of 21 evenings and 14 of 21 nights there is no documentation of removal and/or repositioning of the resident.
3. The licensee failed to ensure that documentation includes the person who applied the device and the time of application. [r. 110. (7) 5.]

a) Resident 001 uses identified restraints.

b) Documentation related to restraint application completed for three months in 2012 does not consistently include the time of application of the device, or who applied the device.

c) The restraint documentation for resident 001 for a specified month in 2012 for two specified restraints are documented on one form. There is no indication related to when each specific device is applied or removed.

d) The restraint documentation for resident 001 for two months in 2012 is identified to be related to the use of chair and bed alarms which are not restraints. There is no indication of other restraints in use at the time. (e.g. tilt wheelchair, front closing seat belt, tabletop). Interview confirms that restraints were used during these months in 2012.

Issued on this 17th day of September, 2012

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