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
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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 15, 19, 20, 2012	2012_198117_0008	Critical Incident

Licensee/Titulaire de permis

CHARTWELL MASTER CARE LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

CHATEAU GARDENS LANCASTER LONG TERM CARE CENTRE
105 MILITARY ROAD NORTH, P.O. BOX 429, LANCASTER, ON, K0C-1N0

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

LYNE DUCHESNE (117)

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 home's Administrator/Director of Care, a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents, observed resident care and services, reviewed the home's Safety: Physical Restraint Policy # LTCE-CNS-H-4, dated May 2012, reviewed two Critical Incident Reports as well as examined the use and application of lap belt restraints on resident wheelchairs.

It is noted that two critical incident inspections, log #O-000676-12 and Log # O-000799-12, were conducted during this inspection.

The following Inspection Protocols were used during this inspection:

Minimizing of Restraining

Responsive Behaviours

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.) 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. (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 LTCHA 2007, s. 6 (7) in that the care set out in the plan of care, was not provided to the resident as specified in the plan.

Resident #1 is a frail elderly resident with limited mobility. Medical orders and the plan of care identify that the resident is to have a 4-point lap belt restraint applied for positioning when the resident is up in his/her wheelchair.

On an identified day in March, 2012, Resident #1 was found on floor, beside his/her wheelchair in his/her room. The resident was assessed and no injuries were noted. The home immediately investigated the resident's fall and found that the resident's lap belt had not been applied as per the plan of care.

On another identified day in March, 2012, Resident #1 was found on the floor beside his/her wheelchair. The resident was assessed and was noted to have small mark to the temple and no other injuries. The resident was started on Head Injury Routine protocols and closely monitored. Progress notes and the home's internal investigation noted that the resident's lap belt had not been applied as per the plan of care. The resident continued to be monitored closely. The next day, the resident was noted to have some discomfort and was transferred to hospital for assessment. Resident #1 was diagnosed as having a fracture.

The home's administrator confirmed that the resident's plan of care was not followed by two PSWs in that the resident's lap belt was not applied on two specified days in March, 2012 resulting in resident #1 falling twice out of his/her wheelchair. Both PSWs received disciplinary measures as per the home's policies. [O-00676-12]

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 related to ensuring the care, related to the use and application of restraints, set out in residents plan of care is provided to residents as specified in the plan, 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 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 comply with O.Reg. 79/10 s. 100 (7) in that every use of a physical device to restrain a resident under section 31 of the Act is not documented for two identified residents: (5) the person who applied the device and time of application; (6) all assessment, reassessment and monitoring, including the resident's response; and (7) every release of the device and all repositioning.

Resident #4 is an elderly resident whose plan of care identifies that he/she requires the use and application of a lap belt restraint when up in his/her wheelchair. The use of lap belt restraint was ordered on August 30 2012. Consent for the use of the restraint was also received on August 30 2012.

The resident's Restraint Monitoring Forms for September 2012 documents the application, assessment, reassessment, and monitoring of the resident's response and when the restraint is released or the resident's repositioning only from the evening of September 25th until September 30th. There is no documentation of the use of the lap belt restraint from September 1st to September 25th 2012.

Interviewed PSW and RN staff could not identify why there was no documentation of the application, monitoring, repositioning and removal of the resident's lap belt in September 2012.

Resident #5 is an elderly resident whose plan of care identifies that he/she requires the use and application of a lap belt restraint when up in his/her wheelchair.

The resident's Restraint Monitoring Forms for September, October and November 2012 have gaps in the documentation of the application, assessment, reassessment, and monitoring of the resident's response and when the restraint is released or the resident's repositioning.

November 2012 - day shift 4 and evening shift of the 13th.

October 2012 - day shift: 4-5-13-27 and 28
October 2012 - evening shift 1-2-3-4-5-6-7-8-10-11-13-16-18-24-25-26-29-30-31

September 2012 - day shift 9-11

2. The licensee failed to comply with O.Reg 79/10, s. 110 (2) (6) in that three identified residents condition were not 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.

The home's policy # LTCE-CNS-H-4 titled "Safety : Physical Restraints", dated May 2012. The policy states under Corporate Procedures, section 9 " The decision to continue the use of a restraint, as well as the type of restraint, shall be re-evaluated prior to each application on an ongoing basis by the Registered Staff, and will be documented on the Restraint Monitoring Form. ".

Resident #1 is a frail elderly resident with limited mobility. Medical orders and his/her plan of care identify that the resident is to have a 4-point lap belt restraint applied for positioning when the resident is up in his/her wheelchair. A review of the March 2012 Restraint Monitoring Form shows that Registered Nursing staff did not re-evaluate the use and application of a lap belt restraint 20 / 30 times during the day shift. It is noted that Registered Nursing staff did not re-evaluate the use and application of Resident #1's lap belt restraint during the day shift of two specified days in March, 2012 when resident #1 fell out his/her wheelchair twice and sustained injuries on one of those identified days in March, 2012. [Log #O-000676-12]

Resident #4 is an elderly resident whose plan of care identifies that he/she requires the use and application of a lap belt

restraint when up in his/her wheelchair. The resident's Restraint Monitoring Forms for September, October and November 2012 show that the registered staff have not consistently reassessed the use and effectiveness of the resident's restraint, at least every eight hours.

November: no reassessment of the resident restraint on the day shift for 1-14th, inclusively
November: no reassessment of the resident restraint on evening shift on 2-3-4-7-8-11-12-13

October: no reassessment of the resident restraint on the day shift for 1st to the 31st, inclusively
October: no reassessment of the resident restraint on evening shift on 1-2-6-7-15-20-29-30 and 31

September - no reassessment of the resident restraint for all shifts from the 1st to the 30th except for 4 shifts.

Resident #5 is an elderly lady whose plan of care identifies that he/she requires the use and application of a 4-point lap belt restraint for positioning when up in his/her wheelchair. The resident's Restraint Monitoring Forms for September, October and November 2012 show that the registered staff have not consistently reassessed the use and effectiveness of the resident's restraint, at least every eight hours.

November: no reassessment of the resident restraint on the day shift for 1-14th, inclusively
November: no reassessment of the resident restraint on evening shift on 2-3-4-7-8-9-12-13

October: no reassessment of the resident restraint on the day shift for 1st to the 31st, inclusively
October: no reassessment of the resident restraint on evening shift on 1-2-6-7-15-17-20-21-29-30 and 31st.

September - no reassessment of the resident restraint on the day shift for 1st to the 30th, inclusively
September - no reassessment of the resident restraint on evening shift on 3-4-7-8-9- 12-13-14-17-18-22-23-24-25 and 30

Interviewed RN #S100, RPN #S101 and Administrator/DOC state that registered staff are to document their reassessment and effectiveness of the restraint on the home Restraint Monitoring Form every shift, as per the home's policy.

Issued on this 20th day of November, 2012

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

Lynne Duchesne #117