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
Jul 2, 2013	2013_196157_0009	000862, 000973, 001668, 001347	Critical Incident System

Licensee/Titulaire de permis

COMMUNITY LIFECARE INC
1955 Valley Farm Road, 3rd Floor, PICKERING, ON, L1V-1X6

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

COMMUNITY NURSING HOME (PICKERING)
1955 VALLEY FARM ROAD, PICKERING, ON, L1V-3R6

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 System inspection.

This inspection was conducted on the following date(s): March 12, 13, 14, April 5, 2013

During the course of this inspection the following critical incidents were inspected: Log #O-000862-12, CI#2693-000010-12; Log #O-000202-12, CI#2693-000022-13; Log #O-001668-12, CI#2693-000033-12.

During the course of the inspection, the inspector(s) spoke with Director of Care, Director of Quality in Nursing, Clinical Nurse Specialist, 2 Registered Nurses, 1 Registered Practical Nurse

During the course of the inspection, the inspector(s) Reviewed the clinical health records for 3 residents, reviewed critical incident reports and related facility investigation reports, reviewed facility policies related to Resident Safety: Zero Lifting, Safe Transfers (Resident Services Manual - Policy #RSL-SAF-025, June 26, 2012), Reporting of Abuse and Neglect (Human Resources Manual - Policy HRM-POL-003, May 29, 2012), Behaviour Management (Resident Services Manual - Policy RSL-BM-010, July, 2012), reviewed procedures for use of bedside lift logos.

The following Inspection Protocols were used during this inspection:
Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Skin and Wound Care

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:

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Log #001668-12
The Kardex and Plan of Care for resident #07 provides direction for lifting/transfer with a mechanical lift.
The plan of care failed to provide clear direction related to the type of sling to be used in the lift. Staff using the incorrect sling resulted in the resident sustaining a fall. [s. 6. (1) (c)]

2. Log #000202-13
Personal Support Worker's responsible for the provision of personal care to resident #12 failed to assess and report a change in the resident's skin condition. The resident's skin condition was not promptly reported to the registered nursing staff to ensure early detection of risk, follow up and treatment of the skin condition.
Staff involved in the different aspects of care of resident #12 failed to collaborate with each other in the assessment of the resident. [s. 6. (4) (a)]

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 plans of care for resident requiring transfer with the use of a mechanical lift, clearly identify the type of sling to be used to ensure safe transfer, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 107 (4).
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 107 (4).
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 107 (4).
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Log #000862-12
Resident #11 was found to have sustained an injury to the hand resulting in the need for subsequent diagnostic tests to investigate the injury.
The Critical Incident report was not submitted until 39 days after the injury occurred.
The licensee failed to submit a report within 10 days of becoming aware of the incident. [s. 107. (4)]

Issued on this 2nd day of July, 2013

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