Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

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347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
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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
Feb 22, 23, 24, 28, 29, Mar 4, 5, 7, 2012	2012_041103_0008	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE KINGSTON
309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4

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

DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Personal Support workers, Registered Practical Nurses, Registered Nurses, Clinical Coordinator, the RAI Coordinator, Director of Care, and the Administrator.

During the course of the inspection, the inspector(s) did a walk through of the home, reviewed the home restraint policies, observed resident restraint application, reviewed resident health care records including resident progress notes, plans of care, medication administration records and referral notes from outside specialists.

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following subsections:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A resident was restrained in a geri chair with an attached table for approximately fifteen hours. The physical device was applied as an immediate action to prevent serious bodily harm to the resident or others.

The Long Term Care Home Act, 2007, S.O. 2007, c. 8 s. 29 (1) states:
Every licensee of a long term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and
(b) shall ensure that the policy is complied with.

The home failed to comply with their policy "Restraints-Physical/Mechanical policy# 08-10-02" in the following manner:
-no alternatives were tried prior to the application of the physical device on the resident.
-the physical device applied as an immediate action was in effect longer than 12 hours without a physician order
-the registered nursing staff failed to initiate the Restraint Assessment form
-the registered nursing staff failed to assess, and reassess the ongoing need for the restraint every 15 minutes and failed to document the assessment
-the registered nursing staff failed to document the resident response to the restraint
-a physician order was not obtained and the restraint was not removed after 12 hours of application

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that residents taking any drug or combination of drugs, including psychotropic drugs had monitoring and documentation of resident response and effectiveness of the drugs appropriate to the risk level of the drugs.

The Medication Administration Records for an identified resident was reviewed over a period of two months.

The resident was ordered Lorazepam as needed for anxiety or aggression. All of the doses indicated he/she received the medication for agitation. Two of the nine administered doses did not indicate the effectiveness of the medication.

The Medication Administration Records for a second identified resident was reviewed over a period of two months.

He/she was ordered Haldol as required for aggression. Both doses indicated it was given for aggression. For the first month reviewed, only one of the two doses indicated the effectiveness of the medication.

The resident received the Haldol on two occasions during the second month reviewed; both doses indicated it was given for aggression. Only one of the two doses indicated the effectiveness of the medication.

The resident was also ordered Seroquel. During the months reviewed, he/she received one dose; there was no indication of the effectiveness of this medication.

The Medication Administration Records for a third identified resident, was reviewed over a period of two months.

He/she was ordered Lorazepam. The reason for the administration of this medication was indicated as crying or agitation. During the first month reviewed, five out of the seven doses did not have the effectiveness of the medication indicated.

He/she received the prescribed Lorazepam on four occasions during the second month reviewed. The reason for the administration of all of the doses was crying. None of the administered doses had the effectiveness of the medication indicated.

WN #3: 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. (3) Where a resident is being restrained by a physical device when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act, the licensee shall ensure that,
(a) the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances;
(b) the resident's condition is reassessed 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 15 minutes, and at any other time when reassessment is necessary based on the resident's condition or circumstances; and
(c) the provisions of section 31 of the Act are complied with before continuing to restrain a resident by a physical device when the immediate action is no longer necessary. O. Reg. 79/10, s. 110 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a resident restrained by a physical device when an immediate action is necessary to prevent serious bodily harm to the resident or others received assessment, reassessment, repositioning, or release from the physical device every fifteen minutes by a member of registered nursing staff based on the resident's condition.

A resident began exhibiting signs of agitation. The decision was made by the Registered Nurse in charge to place the resident in a geri chair with an attached tray.

The resident remained in the geri tray for approximately fifteen hours. During that time, registered nursing staff failed to assess, reassess, reposition or release the resident from the physical device every fifteen minutes.

Nursing staff members, both registered and non registered involved in the incident did receive disciplinary measures including re-education on restraints, resident abuse and additional identified areas.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 16th day of March, 2012

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

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2012_041103_0008
Type of Inspection / Genre d'inspection:	Complaint
Date of Inspection / Date de l'inspection :	Feb 22, 23, 24, 28, 29, Mar 4, 5, 7, 2012
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE KINGSTON 309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~MARILYN C. BENN~~ Margaret Palimaka

To EXTENDICARE CENTRAL ONTARIO INC, you are hereby required to comply with the following order(s) by the date (s) set out below:

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (3) Where a resident is being restrained by a physical device when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant to the common law duty described in section 36 of the Act, the licensee shall ensure that,
(a) the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances;
(b) the resident's condition is reassessed 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 15 minutes, and at any other time when reassessment is necessary based on the resident's condition or circumstances; and
(c) the provisions of section 31 of the Act are complied with before continuing to restrain a resident by a physical device when the immediate action is no longer necessary. O. Reg. 79/10, s. 110 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the application of a physical device when immediate action is necessary to prevent serious bodily harm to the resident or others. The plan shall include how the licensee will ensure ongoing compliance by registered nursing staff with all legislative requirements related to the application of a physical device when immediate action is required.

The plan is to be submitted in writing on or before March 23, 2012 to Inspector, Darlene Murphy by mail to 347 Preston Street, Ottawa, Ontario, K1S 3J4, or by fax at 613-569-9670.

Grounds / Motifs :

1. The licensee failed to ensure that a resident restrained by a physical device when an immediate action is necessary to prevent serious bodily harm to the resident or others received assessment, reassessment, repositioning, or release from the physical device every fifteen minutes by a member of registered nursing staff based on the resident's condition.

A resident began exhibiting signs of agitation. The decision was made by the Registered Nurse in charge to place the resident in a geri chair with an attached tray.

The resident remained in the geri tray for approximately fifteen hours. During that time, registered nursing staff failed to assess, reassess, reposition or release the resident from the physical device every fifteen minutes.

Nursing staff members, both registered and non registered involved in the incident did receive disciplinary measures including re-education on restraints, resident abuse and additional identified areas. (103)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 30, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of March, 2012

Signature of Inspector / Signature de l'inspecteur : [signature]

Name of Inspector / Nom de l'inspecteur : DARLENE MURPHY

Service Area Office / Bureau régional de services : Ottawa Service Area Office