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
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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
Jun 14, 15, Dec 12, 13, 14, 2011	2011_056158_0005	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHWESTERN ONTARIO INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE KIRKLAND LAKE
155 GOVERNMENT ROAD EAST, P.O. BAG 3900, KIRKLAND LAKE, ON, P2N-3P4

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

KELLY-JEAN SCHIENBEIN (158)

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 (DOC), the Clinical Care Co-ordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), the RAI Co-ordinator,Personal Support Workers(PSW), and residents.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, the home's Fall Prevention an Management Program policy, the home's Mechanical Lift policy # 01-02, the home's staff educational plan and inservices provided and observed staff interaction and care with residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A resident's progress notes identified that the resident was more unsteady and developed pitting edema in the lower legs. The resident was provided a walker.
An admission (full) assessment was completed within 14 days of the admission and identified the resident's needs as "assistance of one staff to set up for toileting, and is independent with transferring". The resident's health care records did not include the home's "transfer/mobility" assessment, a re-assessment from physiotherapy or nursing when the resident's needs changed post admission.
The resident was not reassessed after the admission assessment when the resident's care needs changed.
[LTCHA 2007, S.O. 2007, c. 8, s.6 (10)(b)]
2. A resident's plan of care identified the following; "provide good peri-care and set up for toileting, is normally continent but wears a pad for protection".
An assessment completed 14 days post admission identified the resident's needs as "assistance of one staff to set up for toileting and is independent with transferring". The RAP assessment, however, identified that the resident was frequently incontinent and used pads.
The direction as set out in the resident's plan of care was not consistent with either the 14 day post admission assessment or the RAP assessment, thereby not providing clear direction.
[LTCHA 2007,R.O. 2007, c. 8, s. 6 (1)(c)]
A resident's plan of care identified the following; "walks independently, is unsteady at times but does not require an adaptive aid". The resident received a walker post admission assessment, hence, contradicting what is documented in the resident's plan of care.
Clear direction was not set out in this resident's plan of care for the staff who provide direct care.
LTCHA 2007,R.O. 2007, c. 8, s.6 (1)(c)
Fall prevention and management strategies in a resident's plan of care identified "supervise when walking in rooms, corridors and hallways", and "ensure a safe environment". These interventions contradict the direction identified on the plan of care under mobility which stated "walks independently"
Clear direction was not set out in this resident's plan of care for the staff who provide direct care.
[LTCHA 2007, S.O. 2007, c. 8, s.6 (1)(c)]
3. A resident's health care record identified that the resident had a diagnosis related to cognitive impairment, was unable to stand or weight bear and was unable to follow direction.
The resident's plan of care identified that "two staff are required to provide all care qam, qhs, during bath and incontinent change and all transfers".
The resident rolled out of bed and onto the floor while one PSW was providing the resident's evening care. The resident sustained a fracture.
The DOC and Clinical Coordinator confirmed that one staff member provided the resident's care and did not follow the resident's plan of care.
The care set out in this resident's plan of care was not provided.
[LTCHA 2007, S.O. 2007, c. 8, s.6 (7)]
4. A resident was observed by the inspector to be sitting at the edge of the bed, slouched and was shaky as the resident attempted to put on shoes. Staff were observed to enter the room to attend to another resident, however, assistance was not provided to the resident attempting to put shoes on. The resident's plan of care (resident attempting to put shoes on) identified the resident as a moderate risk to fall. The resident was also identified as needing extensive assistance with dressing.
The care set out in this resident's plan of care was not provided.
[LTCHA 2007, S.O. 2007, c. 8, s.6 (7)]

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 all residents who are at risk to fall have written plans of care that provide clear direction to staff who provide their care and that the care set out in the plan of care is provided, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. On Jun.15/11 the inspector observed that a resident had two small skin tears on the lower right arm. The resident stated the tear occurred when " the side rail was lifted by a staff PSW a week or so ago". The resident has a right sided hemiparesis.
2. A resident was observed by the inspector on Jun. 15/11 to be transferred by two staff per maxi lift into the bed. The resident was positioned close to the left edge of the mattress. The bed was then placed in a high position post transfer. The left side rail remained down while the right side rail was raised to the up position. An over bed table was placed on the left side of the bed. The resident's plan of care identified that the resident is "non-weight bearing and requires extensive assistance with bed mobility but can roll side to side". The home did not ensure that the staff used safe positioning techniques when assisting this resident.

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 staff use safe positioning techniques when assisting residents who require extensive assistance with bed mobility, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. A resident fell in the bathroom and hit their head. The resident was transferred to the hospital for assessment related to excessive bleeding from a head wound. The resident returned from hospital but was transferred back when the resident's condition changed. The resident expired at the hospital.
The home's head injury policy identified a specific monitoring procedure for a resident with a head injury. An initial assessment of the resident's vital signs and neuro-signs were completed when the resident returned from the hospital, however, there was no further documentation of the resident's vital signs or neuro-signs found in the resident's progress notes or on the vital sign measurement record. There is documentation that identified that the resident was more confused and lethargic when the RPN went to administer the resident's analgesic at 1430 and subsequently became unresponsive.
The licensee failed to ensure that the resident was reassessed when the resident returned to the home from the hospital after being assessed for a head injury.

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 a post fall assessment is conducted when a resident returns from being assessed at the hospital, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The inspector observed on Jun.15/11 at 1628h that two residents were sitting in their wheel chairs near the end of their beds in their room with the door closed. Their call bells were not accessible to them.
3. The call bells were observed by the inspector on June 15/11 at 1117h to be placed under pillows, at the head of the bed and on the floor in six rooms on one unit. The six residents were resting in their beds and did not have access to their call bells.
4. The call bells were observed by the inspector on June 15/11 at 0935h to be located behind nine residents' headboards or against the wall on second unit. The nine residents were observed resting in the their beds and did not have the call bell accessible at all times.
5. The inspector observed on Jun.15/11 at 1052h that a resident was laying in their bed. The call bell was located behind the head of the bed. The call bell was not accessible.
[O. Reg 79/10, s. 17 (1)(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 ensuring that all residents have access to the home's resident-staff communication device (call bell) at all times, to be implemented voluntarily.

Issued on this 15th day of December, 2011

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