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

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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
Mar 14, 15, 2012	2012_029134_0006	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE MEDEX
1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6

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

COLETTE ASSELIN (134)

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, the Director of Care (DOC), two Assistant Director of Care (ADOC), one Registered Nurse (RN), One Registered Practical Nurse (RPN), one physician, several Personal Support Workers (PSW) and one resident.

During the course of this inspection, the inspector conducted 4 critical incident inspections - log # O-002838-11, O-000190-12, O-000123-12, O-000539-12.

During the course of the inspection, the inspector(s) reviewed several residents' health records and assessed different transfer slings.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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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. (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
(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. The licensee failed to comply with section 6 (4) (a) of the LTCH Act 2007, in that, staff and others involved in different aspect of care did not collaborate with each other in the assessment of an identified resident.

Resident #2's progress notes were reviewed. There is an entry made by the physiotherapist in January 2012, indicating that Resident #2 be transferred via mechanical lift.

The DOC, was interviewed and indicated the change in transfer method from a "2 person assist" to a mechanical lift transfer, did not take place as per the physiotherapist's recommendations made in January 2012. The DOC reported to the inspector that staff continued to use a "2 person assist" transfer, as per the plan of care. The plan of care was not amended to reflect the new transfer method and change in condition of resident #2. According to the DOC the physiotherapist did not communicate the new recommendations, regarding the change in transfer method, to a regulated staff member.

There are several entries in the progress notes made in the early part of January 2012, indicating that resident #2's right foot was red and swollen. There are several chart entries made over a period of 8 days in January 2012, indicating resident #2 was tired, lethargic, refusing food, fluids and medication. The Physician and Nurse Practitioner were not notified in a timely manner of the changes in conditon.

In January 2012 resident #2's right knee and upper leg were observed to be swollen and red. The resident was transferred to hospital for assessment and was diagnosed with a fractured right femur.

Upon return from hospital resident #2 was assessed by the Dietitian and assessed to have lost 2.2 kg over the last month as a result of the change in condition.

2.The Licensee failed to comply with section 6 (1) (c) of the LTCH Act 2007, in that the plan of care does not set out clear directions to staff and others, who provide direct care to the identified resident.

Resident #1's plan of care was reviewed. There is an entry indicating Resident #1 is to have a bath twice a week. There is an entry indicating Resident #1 prefers to take a bath Thursday and Sunday morning.

One PSW, reported to the inspector that Resident #1 is getting one shower per week and one complete bed bath (CBB) on Sundays because of behaviors. The PSW indicated that on Thursday a shower is normally given.

The bath assignment was reviewed and Resident #1 is down for a bath or a shower on Thursday and Sunday morning.

The plan of care was reviewed and under method of transfer, there is an indication that resident #1 is to be transferred using the mechanical lift with 2 people and to use the blue sling. Under toileting, there is an entry indicating resident #1 is able to weight bear and use the sit to stand lift. Three PSWs indicated that the "sit to stand lift" is not used with resident #1 because of a non weight bearing status.

There are two transfer logos, at resident #1's bedside, indicating that the mechanical lift is to be used from bed to chair and that if resident #1 is cooperative, the "sit to stand lift" can be used for toileting.

Resident #1's plan of care specifies to use the blue sling (large) for the resident's transfers. Two PSWs reported they normally use the red or the blue sling for resident #1.

Another PSW, reported to the DOC that on the evening in question in January 2012, the full green sling (medium size) was used to transfer resident #1 to the toilet, using the mechanical lift.

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 the residents' plan of care are reviewed and revised when there is a change in residents' care condition, that the plan of care is developed based on collaborative assessments and that the plan gives clear direction to staff who provide direct care, 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. The licensee failed to comply with section 36 of the O. Reg. 79/10, in that, staff did not use safe transferring devices or techniques when assisting two identified residents.

Resident #1's plan of care specifies that the blue sling (large size) is to be used with the mechanical lift transfers.

Three PSWs, were interviewed, they indicated they use the red sling (x-large) or the blue sling (large), when transferring resident #1 via mechanical lift.

The ADOC, was interviewed and indicated that another PSW, had reported that on the evening in question in January, 2012 the green sling, which is medium size was used to transfer resident #1, when in fact the blue sling was to be used.

Resident #2's progress notes were reviewed. There is an entry made by the physiotherapist in January 2012, indicating that Resident #2 be transferred via mechanical lift".

The DOC was interviewed and reported to the inspector that the change, in transfer method from "2 person assist" to a mechanical lift transfer, did not take place as per the physiotherapist's recommendations, which were made in January 2012. The DOC indicated that staff continued to use a "two person assist transfer". The plan of care was not amended to reflect the change in the transfer method or the resident's change in condition. According to the DOC, the physiotherapist did not communicate the recommendations regarding the change in transfer method for Resident #2 to the regulated staff member.

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 there is full communication between all parties about residents' needs and how such communication will be documented to ensure residents' needs are met, to be implemented voluntarily.

Issued on this 16th day of March, 2012

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

Colette Asselin LTCH Inspector # 134