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
Nov 12, 2013	2013_200148_0045	O-000972-13	Critical Incident System

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE, OTTAWA, ON, K2B-5E6

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

AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 7, 2013, on site.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, Registered Nursing Staff and Personal Support Workers.

During the course of the inspection, the inspector(s) reviewed the health care record of an identified resident, including plans of care, progress notes and Point of Care information. In addition the inspector reviewed the home's investigation notes into the incident and observed the care of the identified resident.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, S.O. 2007, c.8, s.6 (1)(a), whereby the licensee did not ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

The plan of care for an identified resident indicates that the resident is to have an alarm applied to both bed and chair, as applicable. Staff members, who regularly care for Resident #1, stated that the resident does not use an alarm with chair or bed. Staff could not recall if or when such an alarm alarm had been used by this resident.

The current plan of care for an identified resident does not set out the planned care for the resident as it relates to the use of an alarm. [s. 6. (1) (a)]

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:

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:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg 79/10, s. 110 (7) 6., whereby the licensee did not 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 all assessment, reassessment and monitoring, including the resident's response are documented.

In accordance with LTCHA 2007, s.31 (1) a resident may be restrained by a physical device if the restraining of the device is included in the resident's plan of care. With respect to a resident who is restrained under section 31 of the Act, requirements described in section 110 of the Regulations 79/10 must be met. In accordance with O.Reg 79/10, s.110(2)3., a restraint that is applied, under section 31 of the Act, shall be monitored at least every hour while a resident is restrained.

The most current plan of care for an identified resident indicates the use of daily physical restraints. During the course of this inspection the resident was observed to have these physical restraints applied.

Interviews with staff members, who regularly provide care to the identified resident, confirmed that the physical restraints are applied as per the plan of care. Staff were aware of the requirement to monitor the resident while restraints are applied.

A review of the health care record for the identified resident, including progress notes and Follow Up Question reports from Point of Care, indicate that hourly monitoring of the physical restraints are not documented as required by section 110 of the Regulations. In addition, staff confirm that a physical restraint was applied on a specified date. The health care record does not include documentation of the application or removal of that physical restraint on that specified date.

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Issued on this 12th day of November, 2013

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

Amanda Xi RD LTCH Inspector