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

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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
May 22, 2014	2014_334565_0004	T-394-13	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE GIBSON LONG TERM CARE CENTRE
1925 STEELES AVENUE EAST, NORTH YORK, ON, M2H-2H3

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

MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 23, 25, 28, 29, 2014.

During this inspection, the inspector reviewed log CIS-T-344-13 and the inspection #2013_108110_0014 dated July 16, 2013.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Resident Services, Assistant Director of Care, registered nurses, registered practical nurses, personal support workers and resident's family.

During the course of the inspection, the inspector(s) toured the resident home areas, reviewed resident and home records, home's polices and procedures and staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining

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. 49. Falls prevention and management

Specifically failed to comply with the following:

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. The Licensee uses a Post Fall Analysis tool in PointClickCare to assess residents following a fall. Resident #1 was at high risk for falls as per the care plan. In mid-2013, resident #1 fell in his/her room and was diagnosed with a fracture. The resident had a surgery at the hospital and returned to the home later. Interview with the nursing staff indicated that they do not remember if the post fall assessment was completed for this resident after the fall. Record review and interview with the Director of Residence Services confirmed that there was no post fall assessment completed for this resident after the fall. [s. 49. (2)]

2. Resident #2 fell in early 2014 in his/her room with no injury. Record review revealed that there was no post fall assessment completed for this resident after the fall. Review of the Licensee's fall prevention and management policy #LTCE-CNS-G-10 and interview with the Director of Residence Services confirmed that the resident should be assessed using the Post Fall Analysis tool but this was not completed for this resident. [s. 49. (2)]

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 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, to be implemented voluntarily.

WN #2: 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 ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

Record review of the resident #1's plan of care stated that side rails to be in up position while resident in bed for safety. The resident's plan of care does not provide directions for monitoring and repositioning the resident, and the type of side rails restraint to be used. Interview with the Director of Residence Services confirmed that due to the change in the care plan library in April 2013, the previous plan of care which provided directions to the use of side rails restraint, was revised, and the information related to directions to the use of side rails restraint was lost. The new plan of care should have been updated to set out clear directions to staff who provided direct care to the resident but it was not. Interview with five nursing staff confirmed that two of them did not remember the use of side rails for the resident as a restraint. [s. 6. (1) (c)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The Licensee failed to ensure that prior to restraining the resident, alternatives to restraining were considered, and tried, but have not been effective in addressing the risk.

Record review of the care plan indicated that when resident #1 was in bed, he/she had both bed rails up as a physical restrain. The initial restraint order was completed in early 2011. The Licensee applied the restraint for resident #1 until mid-2013. Record review and interview with the nursing staff and the Director of Residence Services confirmed that alternatives to restraining were not considered for the resident prior to the application of the restraint. [s. 31. (2) 2.]

Issued on this 3rd day of June, 2014

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