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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 27, 2016	2016_339617_0019	010592-16	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

SHEILA CLARK (617)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 16, 17, 18, 19, 2016

This Critical Incident System Inspection is related to the following three critical incident reports submitted from the home to the Director:
-resident responsive behaviour intakes,
-resident elopement intake,
-fall prevention intake.

This inspection was conducted concurrently with Follow Up Inspection #2016_463616_0012, Other Inspection #2016_339617_0020, and Complaint Inspection #2016_463616_0013.

During the course of the inspection, the inspector(s) spoke with Executive Director/Director of Care (ED/DOC), Resident Quality Manager (RQM), Director of Support Services (DSS), Office Manager (OM), Resident Assessment Instrument (RAI) Coordinator, Housekeepers (HSK), Laundry Aids (LA), Dietary Aids (DA), Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), residents and family.

Observations were made of the home areas and outdoor grounds, meal services, and the provision of care and services to residents during the inspection. The home's policy and procedures, resident health records and staff training records were reviewed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Falls Prevention
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in their plan.

A Critical Incident (CI) Report was submitted to the Director which identified that resident #003 fell and required further assessment. A review of the CI indicated that resident #003 stood up from their wheelchair and fell forward injuring themselves. The CI indicated that resident #003 used a wheelchair as their primary mode of transportation and required a restraint device. At the time of the incident resident #003 did not have their restraint device engaged and it should have been.

A review of resident #003's health care record indicated at the time of the incident, that a restraint device was to be used when the resident was seated in their wheelchair for safety. Resident #003's care instructed PSW staff to check the restraint device every hour and reposition every 2 hours when applied.

A review of the PSW documentation regarding resident #003's restraint device monitoring indicated the times when it was applied, repositioned, checked and removed. PSW documentation for three hours during the time of the incident was blank.

A review of the home's policy titled "Restraint Implementation Protocols - VII-E-10.00" revised on January 2015, indicated that the PSW was responsible to apply a restraint to a resident according to the manufacturer's specifications and visually check the resident every hour for safety and comfort and document the same on restraint record.

The Inspector interviewed a PSW staff member who reported that when a resident care plan identified the use of a restraint device, they would engage the device when the resident sat in their wheelchair, monitor and check that it's in place, remove it when not in their wheelchair, and document the same.

The Inspector interviewed the ED/DOC who confirmed that the restraint device was not on resident #003 at the time of the fall and should have been according to their plan of care.

2. A Critical Incident (CI) Report was submitted by the home to the Director in which resident #001 known to have a particular responsive behaviour and exhibited this behaviour resulting in a safety risk to the resident.

A review of resident #001's health care record indicated an intervention was required due to their cognitive status. Resident #001's care plan indicated that they exhibited a particular responsive behaviour and that staff were to implement a particular intervention.

A review of resident #001's progress notes indicated that the resident had five episodes of a particular responsive behaviour and one episode where they exhibited the behaviour which resulted in risk to the resident.

The Inspector reviewed resident #001's chart and was not able to find the specific intervention completed for resident #001's particular responsive behaviour on four of the six episodes.

The Inspector interviewed a member of the registered staff who confirmed that the dates of the particular intervention completed for resident #001 were missing and that they should have been done when resident #001 was exhibiting a responsive behaviour.

On May 19, 2016, the Inspector interviewed the Resident Quality Manager who confirmed that it was expected the particular intervention should have been done on the four episodes when resident #001 exhibiting a particular responsive behaviour as identified in their care plan but were not done according to the care plan.

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 the care set out in the plan of care regarding
-restraint application will be provided for those residents that require restraining as specified in their plan
-prevention of an exhibited responsive behaviour will be provided to resident #001 as specified in their plan, to be implemented voluntarily.

Issued on this 6th day of July, 2016

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

Original report signed by the inspector.