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
Division de la responsabilisation et de la performance du système de santé
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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
Jan 24, 25, 27, 30, 31, Feb 6, 7, 13, 15, 2012	2012_138151_0002	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 YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

MONIQUE BERGER (151)

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 Administrator,Director of Care, Nurse Manager, Registered Staff (RNs and RPNs), Personal Support Workers (PSWs), Residents, Families/visitors

During the course of the inspection, the inspector(s) - Observed the delivery of care and services to residents,
- Observed staff to resident interactions,
- Conducted daily walk-through the home
- Observed resident care in regards to safe lift and transfers,
- Observed medication security practices
- Directly observed dining and meal delivery service,
- Reviewed related policies and procedures ,
- Reviewed falls prevention program,
- Reviewed resident health care records

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Personal Support Services

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

Specifically failed to comply with the following subsections:

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 Ministry received a CIS report advising that a resident had suffered a fall and required hospital transfer for further assessment and treatment. During the record review, Inspector 151 noted that the care plan was explicit in directing staff. The excerpt is copied as written (bolded areas as is in the plan of care): " WHEN STAFF PORTER [the resident] USE THE FOOT RESTS - they are located in [the] closet in a mesh bag". Inspector reviewed the post-fall analysis dated for the fall. In section 6 - Preventative steps, the question reads: "What should/could have been done differently to reduce the risk of another fall?" The author responded: " when transporting resident, foot rests need to be used" This confirmed that the resident's foot rests were not in place at the time of the fall.

The home did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [O.Reg.79/10, 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 to ensure that the care set out in the plan of care is provided to to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. On January 30, 2012 Inspector observed a staff person not designated as one to have unrestricted access to medication rooms to have possession of medication room keys. Inspector directly observed that this staff person's access to the medication room was not supervised by any Registered Staff. In an interview with Inspector, it was confirmed that the staff person was neither a Pharmacy Technician, Pharmacist or Registered Nurse. Part of the work duties of this person was the monitoring, ordering and re-stocking of Government Stock Medications. The home has not ensured that steps are taken to ensure the security of the drug supply, including, access to these areas restricted to persons who may dispense, prescribe or administer drugs in the home and the Administrator.[O.Reg.79/10, s.130.2]

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 steps are taken to ensure the security of the drug supply, including the restriction of access to these areas to include only:
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator, 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. ******The Ministry received a Critical Incident Report (CIS) advising that a resident had suffered a fall resulting in transfer to hospital. Inspector reviewed the resident's health care record and observed that the post fall assessment for this fall was not done until until one month after the actual fall. The home did not conduct a post-fall assessment at the time of the fall. [O.Reg.79/10, s.40.(2)]

2. *****The Ministry received a further CIS report advising that a resident had suffered a fall resulting in a transfer to hospital for further assessment. In addition, record review showed that this resident had a fall two (2) days earlier as well. Record review shows that the post-fall assessment for the first fall was begun the following day but as of the day of the inspection, remained in progress. No post fall assessment was found for the fall reported in the CIS. For both of these falls, the home did not complete a post-fall assessment. [O.Reg.79/10, s.40.(2)]

3. ****** The Ministry received a further CIS report advising that a resident had suffered a fall resulting in a transfer to hospital for further assessment. Inspector reviewed the resident's health care record and could not locate a post fall assessment for this fall. [O.Reg.79/10, s.40.(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 conditions or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment specifically designed for falls, to be implemented voluntarily.

Issued on this 15th day of February, 2012

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

Monique G. Berger (151)