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
Direction de l'amélioration de la performance et de la conformité

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Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 11, 14, 15, 16, 17, 18, 22, 24, 25, 2012	2012_139163_0013	Complaint

Licensee/Titulaire de permis

ps Extendicare Canada Inc, 3000 Steeles Ave E, Suite 700, Markham ON L3R 9W2.
~~Sault Area Hospital~~
~~969 Queen St. East, SAULT STE. MARIE, ON, P6A-2C4~~

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

GREAT NORTHERN NURSING CENTRE LIMITED
860 Great Northern Road, Sault Ste Marie, ON, P6A-5K7

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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), registered staff, personal support workers (PSWs), and residents.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident care and interactions, reviewed health care records, critical incident system information and supporting documentation, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Minimizing of Restraining

Pain

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following subsections:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has not ensured that the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care if the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker (SDM) of the resident with authority to give that consent.
Prior to May 15, 2012, the plan of care for resident 003 indicates that two half rails were used for bed mobility. Staff member S-015 reported to the inspector on May 15, 2012 that the two half rails were considered a PASD for this resident to assist with bed mobility. Inspector reviewed the health care record for resident 003 with regards to a consent for the two half rails being used as a PASD. A resident/SDM consent was not located. Staff member S-015 confirmed to the inspector on May 15, 2012 that the home had not obtained a resident/SDM consent for the use of the PASD for resident 003 or any other resident currently using a PASD in the home. [LTCHA, 2007, c. 8, s. 33 (4)]

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 use of PASDs have been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #2: 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 licensee has not ensured 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.
Resident 003 had a fall with a resulting injury in the month of November 2011 which required a transfer to hospital. Inspector reviewed the health care documentation regarding this incident. A post-fall assessment was not located related to this resident's fall. Inspector interviewed staff member S-009 on May 14, 2012 who confirmed that a post-fall assessment was not conducted for this resident using a clinically appropriate instrument that is specifically designed for falls [O. Reg. 79/10, s. 49 (2)]

WN #3: 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).

Findings/Faits saillants :

1. The licensee has not ensured that the written plan of care for each resident provides clear direction to staff and others who provide direct care to the resident.
Resident's 003 plan of care indicates a risk for skin breakdown related to immobility (extensive assistance x 2 staff members related to weakness) and incontinence. The plan of care directs staff to reposition resident every 2-4 hrs while in bed. On May 14, 2012 inspector interviewed staff members S-016, S-017 and S-018 who were familiar with resident's 003 care. One staff member reported that resident 003 was to be repositioned every 1 1/2 hours while the other two staff members were unsure of what the time requirements were for repositioning resident 003. Inspector interviewed S-015 on May 16, 2012 who informed the inspector that the range of 2-4hrs for repositioning was not appropriate for this resident and that it did not provide clear direction for staff. [LTCHA, 2007, S.O.c.8,s.6(1)(c)]

Issued on this 25th day of May, 2012

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

Diana Stedmund, #163

Ontario

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Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

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Extendicare Canada Inc
3000 Steeles Ave East,
Suite 700
Markham, Ontario L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée
Great Northern Nursing Centre
860 Great Northern Road, Sault Ste. Marie, ON P6A 5K7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
Diana Stenlund, #163

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/ LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ORDER #/ GENRE DE MESURE/ORDRE NO	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
Long Term Care Homes Program Manual Criterion B2.4 (now closed)	Unmet Criterion	Feb 17/2009 Nursing Inspection	

Issued on this 25th day of May, 2012.

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

Diana Stenlund, #163