Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DIANA STENLUND (163)
Inspection No. / No de l'inspection :	2012_139163_0017
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	May 29, 30, 31, Jun 1, 4, 5, 6, 7, 11, 12, 13, 14, 2012
Licensee / Titulaire de permis :	EXTENDICARE ~~NORTHWESTERN ONTARIO~~ CANADA INC 333 York Street, SUDBURY, ON, P3E-4S4
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JAMES R. FOREMAN

To EXTENDICARE NORTHWESTERN ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that plans of care for residents 007 and 009 who experience responsive behaviours, and any other residents with responsive behaviours, provides clear directions regarding management of these responsive behaviours to staff and others who provide direct care to residents. The plan shall be submitted to Diana Stenlund, LTC Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 159 Cedar Street, Suite 603, Sudbury ON, P3E 6AE (Fax# 705-564-3133) by June 25, 2012.

Grounds / Motifs :

1. The licensee has not ensured that the plan of care sets out clear directions to staff and others who provide direct care to the resident.
Inspector reviewed the supporting health care documentation for a Critical Incident that involved resident 009 with responsive behaviours who was reported to have received improper/incompetent treatment in relation to the administration of medication in March 2012. At the front of the resident's health care record there is a hand written note on a small separate piece of paper which indicates to contact a family member if resident experiences responsive behaviours. The Inspector interviewed staff member S-0011 who reported that when the resident was experiencing the responsive behaviours during that reported incident, registered staff did not call the family member as required as it was not clearly indicated to staff, and as a result, two staff were required to assist the RPN with the administration of medication while the resident was experiencing responsive behaviours. S-0011 added that the information should have also been included in the "Care Plan" document so that staff were clear on the need to involve the designated family member when the resident exhibited responsive behaviours. [LTCHA, 2007,S.O. c.8,s.6(1)(c)] (163)
2. The licensee has not ensured that the plan of care sets out clear directions to staff and others who provide direct care to the resident.
Inspector reviewed a Critical Incident report where Resident 007 was reported to be involved in a resident to resident altercation in September 2011. The inspector reviewed the health care progress notes which revealed on several occasions after the incident in September 2011 that resident 007 continued to show responsive behaviours however the "Care Plan" document does not address the resident's responsive behaviours. Inspector interviewed S-0011 on June 5, 2012 about the "Care Plan" document for resident 007. S-0011 acknowledged that the "Care Plan" document does not adequately provide clear directions for staff regarding responsive behaviours for resident 007. [LTCHA, 2007,S.O.c.8,s.6(1)(c)] 163
3. Three previous VPCs were issued on June 06, 2011, Oct 24, 2011 and Oct 26, 2011 related to the same section of the Act. [LTCHA,2007 S.O. 2007,c.8,s.6(1)(c)] (163)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 20, 2012

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
~~55 St.~~ Clair Avenue West
Suite ~~800, 8th~~ Floor
Toronto, ON ~~M4V 2Y~~2
Fax: 416-327-7603

1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 14th day of June, 2012

Signature of Inspector / Signature de l'inspecteur : Diana Stenlund, #163

Name of Inspector / Nom de l'inspecteur : DIANA STENLUND

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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 29, 30, 31, Jun 1, 4, 5, 6, 7, 11, 12, 13, 14, 2012	2012_139163_0017	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE ~~NORTHWESTERN ONTARIO~~ CANADA INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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 Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Care (2) (ADOCs), registered staff, personal support workers (PSWs), activity aides and residents.

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

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 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 plan of care sets out clear directions to staff and others who provide direct care to the resident. Inspector reviewed a Critical Incident report where Resident 007 was reported to be involved in a resident to resident altercation in September 2011. The inspector reviewed the health care progress notes which revealed on several occasions after the incident in September 2011 that resident 007 continued to show responsive behaviours however the "Care Plan" document does not address the resident's responsive behaviours. Inspector interviewed S-0011 on June 5, 2012 about the "Care Plan" document for resident 007. S-0011 acknowledged that the "Care Plan" document does not adequately provide clear directions for staff regarding responsive behaviours for resident 007. [LTCHA, 2007,S.O.c.8,s.6(1)(c)]
2. The licensee has not ensured that the plan of care sets out clear directions to staff and others who provide direct care to the resident. Inspector reviewed the supporting health care documentation for a Critical Incident that involved resident 009 with responsive behaviours who was reported to have received improper/incompetent treatment in relation to the administration of medication in March 2012. At the front of the resident's health care record there is a hand written note on a small separate piece of paper which indicates to contact a family member if resident experiences responsive behaviours. The Inspector interviewed staff member S-0011 who reported that when the resident was experiencing the responsive behaviours during that reported incident, registered staff did not call the family member as required as it was not clearly indicated to staff, and as a result, two staff were required to assist the RPN with the administration of medication while the resident was experiencing responsive behaviours. S-0011 added that the information should have also been included in the "Care Plan" document so that staff were clear on the need to involve the designated family member when the resident exhibited responsive behaviours. [LTCHA, 2007,S.O. c.8,s.6(1)(c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following subsections:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has not ensured that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations for behaviour management. Inspector interviewed staff members S-0011 and S-0015 about the training for staff that provide direct care have received on behaviour management. Staff member S-0015 provided records of attendance which indicated that in 2011, 104/150 of the direct care staff received training on behaviour management. Inspector interviewed direct care staff members S-0019, S-0020, S-0021, S-0022, and S-0023 who reported that they had not received training on behaviour management since at least 2010. [LTCHA,2007,S.O.c.8,s.76(7)3]

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 all staff who provide direct care to resident receive, as a condition of continuing to have contact with resident, training in the areas set out at times or intervals provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has not ensured that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.
Critical Incident reports, along with supporting health documentation dated in the months of September 2011 and October 2011 indicated that two residents received medications that were not prescribed for them. Staff members S-0010 and S-0011 confirmed that both medication errors did occur and that both residents required treatment in hospital. [O. Reg. 79/10, s.131(1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #4: 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 has been assessed and, if required, a post-falls assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls. In August 2011 resident 003 had a fall that resulted in injury and transfer to hospital. Inspector reviewed the health care record for resident 003 however was unable to locate a post-fall assessment related to this fall incident. Inspector interviewed staff members S-0011 and S-0016 on May 31, 2012. They confirmed that a post-fall assessment was not completed and should have been conducted on resident 003 after this resident had fallen in August 2011. [O.Reg 79/10,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 residents have fallen, the resident is assessed and, if required, a post-falls assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 30. Protection from certain restraining

Specifically failed to comply with the following subsections:

s. 30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:
1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30. (1).

Findings/Faits saillants :

1. The licensee has not ensured that no resident of the home is restrained, in any way, for the convenience of the licensee or staff. Inspector reviewed a Critical Incident report and the supporting health care documentation which outlines two incidents of restraining involving the same resident. Both incidents occurred in January 2012. Inspector interviewed S-0011 who reported that as a result of the home's investigation, both actions of restraining resident 006 were for the convenience of staff. [LTCHA, 2007,S.O.c.8,s.30(1)1]

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

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:

CORRECTED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
LTCHA, 2007 S.O. 2007, c.8 s. 8.	CO #001	2011_056158_0016	163

Issued on this 15th day of June, 2012

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

Diana Stenlund, #163