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

Division de la responsabilisation et de la performance du système de santé
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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
Jul 17, 2013	2013_138151_0026	S-000064,000028,00027,00007-13	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

MONIQUE BERGER (151)

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): July 8,9,10,11,12, 2013

This inspection involved the following logs:
S-001386-12 related to CI 2590-000064-12
S-000178-13 related to CI 2590-000028-13
S-000090-13 related to CI 2590-000007-13

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Manager of Environmental Services, Food Service Supervisor, Registered Staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s)
- directly observe the care and service delivery to residents
- reviewed residents' health care records
- reviewed home's policies, procedures, protocols in regards to critical incident reporting
- reviewed staff education initiatives in the last 12 months in regards to abuse policy, falls management, care planning, resident assessment
- reviewed the home's policies, procedures, protocols and programs in regards to falls prevention management
- reviewed the home's policies, procedures, protocols and programs in regards to planning for loss of essential services
- reviewed the home's emergency plan to provide for meals during elevator breakdown
- reviewed the home's policies, protocols and procedures in relation to responsive behaviours

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance

Critical Incident Response

Falls Prevention

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, ss. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, ss. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, ss. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. Inspector reviewed the Critical Incident report issued to the Ministry regarding improper or incompetent treatment of care of a resident and noted that the incident was not reported to the Ministry until 18 days after the incident. In an interview, Director of Care confirmed the management of the home were made aware of the incident 18 days prior to the critical incident report being forwarded to the Ministry. DOC stated "there is no real excuse" in regards to the delay.
The person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident did not immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (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 any person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident immediately reports the suspicion and the information upon which it was based to the Director, 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:

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. Resident #002 fell and required transfer to hospital for further assessment and treatment. As part of this inspection process, Inspector reviewed the resident health care record and noted the resident had had 6 falls since the beginning of 2013. For one of the reviewed resident falls, no post-fall analysis/assessment was found in the health care records. Inspector enlisted the assistance of staff person # 004 to find the record and it was confirmed that no post-fall assessment was done for this fall. As the resident had a history of frequent falls, there was circumstance to warrant analysis of each of the falls and for the home to implement it's falls prevention program in consideration of the findings of the analyses.

When the resident fell, the resident did not have a post-fall assessment conducted using a clinically appropriate assessment instrument that is specifically designed for falls. [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, where the condition or circumstances of the resident require, the home conducts a post-fall assessment using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. 1. On July 9, 2013, Inspector observed a treatment cart in the hallway by a resident's room and that there was no staff in direct view of the cart. Inspector observed that the cart was unlocked.

At this same time, Inspector observed that a resident was behind the desk area and rummaging in the drawers.

Inspector was able to view the contents of the cart with no interference from any staff. Inspector observed the following:
- top drawer contained all the prescription creams and ointments for the residents on the unit
- bottom drawer contained a bottle of Hydrogen Peroxide and a bottle of Dovidine both of these having hazard warnings that the solution were for external use only and to avoid any splashing in eyes.
Inspector stayed by the cart until staff returned.

2. On July 10, 2013, Inspector observed a treatment cart in the hallway by a resident's room and that there was no staff in direct view of the cart. Inspector observed that the cart was unlocked. On top of the cart was an opened bottle of Dovidine, the cap off and to the side of the bottle.
Inspector was able to view the contents of the carts with no interference from any staff. Inspector observed the following:
- top drawer contained all the prescription creams and ointments for the residents on the unit
- bottom drawer contained a bottle of Baxedine 2%-70%. Both of these solutions [Baxedine and Dovidine] had hazard warnings that the solutions were for external use only and to avoid any splashing in eyes.
Inspector stayed by the cart until the staff person returned.

The home did not ensure that drugs are stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a) (ii)]

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 drugs are stored in an area or a medication cart that is secure and locked., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. Inspector reviewed the home policies , procedures, protocols and program related to the prevention and management of resident falls. Inspector noted that in the policy: RESI-10-02-02 POST FALL ASSESSMENT, staff are directed to "complete a post fall assessment after each fall a resident experiences [and to do so] within the first 24 hours". Inspector reviewed the health care records for resident #002 and noted that the resident had 6 falls since January 2013. One of six of the post-fall assessments could not be found. In addition, three of six of the post-fall assessments did not occur within 24 hours of the fall.

The licensee did not ensure that the home's policy and procedures related to prevention of resident falls were complied with. [s. 8. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1) or (3) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The home filed Critical Incident Report with the Ministry apprising them that the large elevator in the home had broken down. The home advised the Ministry it had invoked it's emergency disaster plans and were using these measures to meet resident needs; i.e. menus changed to be all cold food items.

The information on the Critical Incident Report indicated that the elevator was to be up and running in 3 days.

Upon receipt of the Critical Incident Report, the Triage Inspector spoke to the home and requested updates in regards to progress of repairs. None were received until the elevator was fully operational: a total of 16 days post-incident.

The licensee did not make a report in writing to the Director of any of the incidents described in r.107(1) and r. 107(3), within 10 days of becoming aware of the incident. [s. 107. (4) 1.]

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Issued on this 17th day of July, 2013

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

Monique G. Berger (151)