Ministry of Health and Long-Term Care	Ministère de la Santé et des Soins de longue durée
Inspection Report under the Long-Term Care Homes Act, 2007	**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
Direction de l'amélioration de la performance et de la conformité

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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 13, 2014	2014_336580_0008	S-000163-14	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

VALA MONESTIMEBELTER (580), MONIKA GRAY (594)

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 20, 21, 22, and 23, 2014

This inspection is in relation to Log #S-000163-14

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs).

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas, observed staff to resident interactions, the provision of care to residents, reviewed a resident's health care record, staff records and various policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. According to Critical Incident 2590-000006-14, Resident #001 had a fall and sustained an injury for which they were transferred to hospital. Inspector 594 reviewed

the health care record of resident #001 including the care plan and Kardex..

The care plan identified the following:
• Extensive assistance of one staff with dressing, resident stands holding the rail when putting their pants on;
• Staff to ensure Resident #001 uses walker all the time, independent after staff set up;
• Encourage and remind Resident #001 to use their walker;
• Falls Physical limitations with interventions: Resident #001 often gets themselves out of bed and forgets to put footwear on their feet; resident will sometimes run or shuffle quickly down hall, please help slow resident down and remind not to run; Please encourage resident to use their walker, resident tends to forget it when they get to the end of the hall. Please return it to resident when you see them not using it;
• Activities with intervention: Resident #001 likes to walk the hallway with their walker;
• Transferring: INDEPENDENT: Resident #001 is full weight bearing and is able to get in and out of bed, on and off toilet and ambulates around unit on her own;
• Toileting: EXTENSIVE ASSISTANCE X1 STAFF: requires weight bearing assistance

On May 21, 2014, at 14:25, Inspector 594 observed Resident #001 in bed with the call bell within reach, bed alarm secured to resident's clothing, two (2) bedrails up, running shoes on and laced. Wheelchair and walker were close to the bed. At 11:49 on May 22, 2014 Inspector 594 observed resident sitting in their wheelchair in the dining room with Tabs alarm secured to resident's shirt posterior and placed in pocket at back of their wheelchair.

On May 22, 2014 Inspector 594 interviewed Staff 207, who had provided care for Resident #001 that morning. Staff 207 told the inspector that resident #001 requires extensive assistance of 1 staff for transfer, and sometimes Resident #001 tries to stand and that an alarm on bed or chair needs to be applied. Staff 207 was not sure why Resident #001 needs the alarms, but uses them because is told to and Resident #001 has it on. Staff 207 demonstrated to Inspector 594 where to look in the electronic documentation for the alarms, but was not able to find the information.

Resident #001's care plan does not provide clear direction related to transferring and toileting. There is no indication in the care plan that bed/chair alarms are to be used for Resident #001.

With respect to the bed alarms, on May 22, 2014 Inspector 594 completed a review of

"Environmental Controls Policy" #RESI-10-01-05 which states "device must be identified in care plan" and to "document the application and removal in e-documentation system each shift."

On May 22, 2014 at 1152 Inspector 594 interviewed Staff 208 who stated that "bed/chair alarms are used when a resident is at risk of getting out of chair, has a history of falls or for their safety. If a bed/chair alarm is initiated, there will be documentation in the report and an order from the doctor is required and care plan is updated."

On May 30, 2014, ADOC 002 told inspector 594 in a phone interview, that Resident #001 has had a progressive decline, and now is not able to stand anymore.

The licensee failed to ensure that there is a written plan of care for resident #001 that sets out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

Issued on this 13th day of June, 2014

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