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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Oct 30, 31, Nov 1, 2012	2012_038197_0032	Other

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

EXTENDICARE HALIBURTON
167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, the Dietary Manager, the Resident Program Manager, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers, a family member and residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, reviewed Residents' Council meeting minutes and a resident health care record, observed the lunch meal and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Dining Observation

Residents' Council

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 O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following subsections:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 101(2) in that they did not ensure that a documented record was kept in the home in relation to a verbal complaint that was made to the home regarding the care of a resident.

On October 30, 2012, two staff members reported to the inspector that they had concerns related to inappropriate communication between one of their co-workers and a resident.

During an interview with the Administrator/Director of Care on the same date, she stated that these staff concerns had been brought to her and that she had conducted an investigation into the concerns. When asked for documentation related to the concerns and the investigation the Administrator/Director of Care stated that she did not document the staff concerns or her investigation.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 58. Residents' Council assistant

Specifically failed to comply with the following subsections:

s. 58. (1) Every licensee of a long-term care home shall appoint a Residents' Council assistant who is acceptable to that Council to assist the Residents' Council. 2007, c. 8, s. 58. (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 58(1) in that the licensee has not appointed a Residents' Council assistant to assist the Residents' Council.

On October 30, 2012 during an interview with the Residents' Council President, she stated that the home has not appointed a Residents' Council assistant to the Residents' Council.

During an interview with the Administrator/Director of Care on the same date, she stated that sometimes the Residents' Council will invite staff members to their meetings to assist them, but confirmed that the home has not formally appointed a Residents' Council assistant to the Residents' Council.

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).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that the written plan of care does not set out clear directions to staff and others who provide direct care to the resident.

The plan of care last reviewed in October 2012 for resident #1 states that he/she displays inappropriate and disruptive behaviour related to his/her diagnosis.

Interviews with the Dietary Manager, the Resident Program Manager and the Administrator/Director of Care indicated that there have been many conflicts between resident #1 and other residents and that this has recently escalated.

The written plan of care does not indicate this recent escalation of behaviours and does not specify methods or an approach of how staff should re-direct the resident in response to these behaviours.

During an interview with Resident #1's substitute decision maker (SDM), he/she stated that the resident receives inconsistent messages from staff in response to his/her behaviours.

Interviews with two direct care staff indicated that there are inconsistencies in how different staff members re-direct resident #1 when he/she displays behaviours and also mentioned that at times they feel a staff member responds inappropriately to resident #1's behaviours.

During an interview with the Administrator/Director of Care she stated that most staff are clear on how to re-direct resident #1, but recognized there is an inconsistent approach amongst staff.

2. The licensee has failed to comply with LTCHA 2007, s. 6(5) in that a resident's substitute decision maker (SDM) was not given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specified date a staff member reported and the inspector observed a change that had been made to resident #1's plan of care related to dining service.

Interviews with the Dietary Manager, Administrator/Director of Care and the Resident Program Manager indicated that this change was made due to complaints by other residents about resident #1's recent behaviour in the dining room.

On October 30, 2012 the home indicated to the inspector that resident #1 has a family member who is his/her substitute decision maker (SDM).

During an interview with resident #1's SDM, he/she stated that a change was made to the resident's plan of care related to dining service. The resident's SDM stated that he/she noticed the change when visiting resident #1 in the home and he/she is not aware of why the change was made. The resident's SDM further stated that he/she does not feel they were involved in the decision to make the change and that he/she does not think the change is right or the solution to the problem.

On October 30 and 31, 2012 resident #1's health care record was reviewed. There is no clinical documentation related to changing the resident's plan of care or a discussion being held with the resident's SDM.

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 written plan of care sets out clear directions to staff and that the resident or resident's substitute decision maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

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Issued on this 5th day of November, 2012

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

Jessica Pattin, RD