Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
Janaury 18 and 19, 2011	2011_192_2858_18Jan102710	Complaint H - 03119

Licensee/Titulaire
Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, ON, L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée
Extendicare Hamilton, 90 Chedmac Drive, Hamilton, ON, L9C 7S6

Name of Inspector(s)/Nom de l'inspecteur(s)
Debora Saville Nursing Inspector #192

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a critical incident inspection.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Registered Nurse, Registered Practical Nurse, and Personal Support Workers (PSW).

During the course of the inspection, the inspector: Reviewed personal health information, policy and procedure.

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

Findings of Non-Compliance were found during this inspection. The following action was taken:

5 WN
1 VPC
1 CO: CO #001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(1)(c)

Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

Findings:

A specified resident sustained an injury. The resident was hospitalized, underwent surgery and returned to the home. The plan of care does not provide clear direction to staff on the specified resident's current care needs.

1. The plan of care for the specified resident does not provide clear direction on the residents needs, including pain management, changes to activities of daily living (e.g. bathing needs), mobility and transfer or continence needs.
2. Direction provided in the plan of care relates to the specified resident's pre-injury status. No updates were completed on return from hospital.
3. Interventions to prevent falls have not been updated to reflect the specified resident's current status and do not provide clear direction for staff.
4. The transfer documents from hospital indicated that the resident requires specific monitoring. There is no record of the need for the specific monitoring on the plan of care.
5. The plan of care for a specified resident indicates "weight bears and transfers self independently". The PSW flow sheet for the week Jan 9-15, 2010 indicates the specified resident received extensive assistance from 1-2 staff.
6. The plan of care for a specified resident indicates under bowel and bladder function that the resident is independent. The PSW flow sheet indicates the resident is totally dependent, incontinent with use of a pad or brief.
7. There is no reference to the use of a side rail in the plan of care - the PSW flow sheet indicates that a specified resident consistently has one full side rail in place.
8. The 6 day Bowel and Bladder Assessment done on a specified resident indicates the use of incontinence products. The plan of care indicates the resident is independent for bowel and bladder- the use of incontinence products is not identified.
9. A specified resident is identified in the plan of care as requiring one side rail when in bed. PSW flow sheets indicate the consistent use of 2 side rails. It was observed that 2 side rails were in use on January 18 and 19, 2011.
10. The plan of care for a specified resident requires the assistance of one staff member for dressing; the PSW flow sheets indicate consistently that 2 staff are required to dress the resident.

Inspector ID #:	Nursing Inspector #192

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 ensuring that the plan of care for a specified resident and the plans of care for all other resident's of the home provides clear direction to staff and others who provide care to the resident.

WN #2: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(10)(b).

The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(b) the resident's care needs change or care set out in the plan is no longer necessary;

Findings:
A specified resident sustained an injury. Was hospitalized, underwent surgery and returned to the home. The plan of care was not updated on the resident's return to the home.

1. The transfer notes from the hospital and a physiotherapist seeing a specified resident identified that specific monitoring should be put in place. The required monitoring was not included in the plan of care.
2. The physiotherapist noted that the specified resident was seen on return from hospital, there are no further notes related to physiotherapy assessment or treatment. The plan of care does not include plans for postoperative rehabilitation.
3. The specified resident returned with an incision following surgery - care and monitoring of the incision were not included on the plan of care.
4. The specified resident had sustained a fall - no fall risk assessment was completed on return from hospital and no new interventions were put in place giving consideration to the changes in mobility status, continence, or pain.
5. There is no reference to pain within the plan of care - no interventions pharmaceutical or non-pharmaceutical for the management of a specified resident's pain.
6. In addition, the documentation provided by the hospital indicates that the resident sustained a minor complication. No addition monitoring related to the complication was included in the plan of care.

Inspector ID #:	Nursing Inspector #192

WN #3: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, s. 6(4)(a)

The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other;

Findings:
A specified resident fell and sustained an injury.

1. On the specified resident's return to the home, there is no evidence of a comprehensive assessment completed by nursing staff related to risk of falls, pain, or changes in mobility. The plan of care was not updated to reflect the changing needs of the resident.

2. The physiotherapist completed a note indicating that there should be changes to the plan of care. There is no update to the plan of care to reflect these changes.
3. The specified resident sustained a minor complication while hospitalized. There is no indication in the plan of care that the interdisciplinary team addressed the needs of this resident.

Inspector ID #:	Nursing Inspector #192

WN #4: The Licensee has failed to comply with O. Reg. 79/10 s.107(3)4

The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
(4) An injury in respect of which a person is taken to hospital.

Findings:

1. A specified resident sustained a fall with injury resulting in hospitalization. The Director was notified through a critical incident report 15 days after the incident. Incidents causing injury in respect of which a person is take to hospital require reporting no later than one business day after the occurrence.
2. A specified resident was transferred to hospital with injury. The incident was not reported to the Director as required in the Regulation. A report had not been sent to the Director as of Tuesday January 18, 2011 at 1600 hours, the home was instructed at this time that a critical incident report is required when there is an injury that requires a Resident to be hospitalized. A report had not been sent to the Director as of January 27, 2011.

Inspector ID #:	Nursing Inspector #192

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8, 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.

Findings:

A specified resident sustained an injury was hospitalized, underwent surgery and returned to the home. No post-fall assessment was completed on this resident at the time of the fall, on return from hospital, or following a subsequent fall that occurred.

Inspector ID #:	Nursing Inspector #192

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**

	Deborah Saville
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). March 9, 2011

Ontario

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Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Debora Saville	**Inspector ID #**	192
Log #:	H - 03119		
Inspection Report #:	2011_192_2825_18Jan102710		
Type of Inspection:	Critical Incident		
Date of Inspection:	January 18 and 19, 2011		
Licensee:	Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, ON, L3R 9W2		
LTC Home:	Extendicare Hamilton, 90 Chedmac Drive, Hamilton, ON, L9C 7S6		
Name of Administrator:	Patti Green		

To Extendicare (Canada) Inc. you are hereby required to comply with the following order by the date set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: *Long-Term Care Homes Act, 2007*, O. Reg. 97/10 s.107(3)4

The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
(4) An injury in respect of which a person is taken to hospital.

Order:

The licensee shall immediately forward to the Director a critical incident report related to the transfer of a specified resident to hospital with injury and shall include results of any investigation completed by the licensee to determine the cause of the injury. In addition, the licensee shall ensure that future incidents involving injury in respect of which a person is taken to hospital is submitted no later than one business day after the occurrence of the incident.

Grounds:

A specified resident sustained a fall resulting in injury. The Director was not notified of the incident until a critical incident report was sent to the Ministry of Health and Long Term Care 15 days following the incident.

A specified resident was transferred to hospital with an injury. The incident was not reported to the Director as required in the Regulation. A report had not been sent to the Director as of Tuesday January 18, 2011 at 1600 hours, the home was instructed at this time that a critical incident report is required no later than one business day after the occurrence, when there is an injury that requires a resident to be hospitalized. A report had not been sent to the Director as of January 27, 2011.

This order must be complied with by:	Immediately

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 service for the Licensee.

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

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

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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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

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.

Issued on this 9th day of March, 2011.	
Signature of Inspector:	Debora Saville
Name of Inspector:	Debora Saville Nursing Inspector #192
Service Area Office:	Hamilton Service Area Office Ministry of Health and Long Term Care Performance Improvement and Compliance Branch 119 King Street West, 11th Floor Hamilton, Ontario, L8P 4Y7