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 prévue le Loi de 2007 les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 23, 2017;	2016_322156_0010 (A2)	023985-16	Resident Quality Inspection

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 HAMILTON
90 CHEDMAC DRIVE HAMILTON ON L9C 7S6

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

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 prévue le Loi de 2007 les foyers de soins de longue durée

CAROL POLCZ (156) - (A2)

Amended Inspection Summary/Résumé de l’inspection modifié

Summary added to grounds

Issued on this 23 day of February 2017 (A2)

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

Original report signed by the inspector.

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 prévue le Loi de 2007 les foyers de soins de longue durée

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

CAROL POLCZ (156) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 10, 11, 15, 16, 17, 18, 22, 23, 24, 25, 26, 2016

The following were inspected simultaneously with the RQI inspection:

CIS 016546-15 related to falls prevention and management

CIS 018306-15 related to falls prevention and management

CIS 029343-15 related to medication

CIS 000250-16 related to medication

CIS 010371-16 related to prevention of abuse

CIS 011760-16 related to prevention of abuse

CIS 016330-16 related to medication

CIS 022107-16 falls prevention and management

Complaint 032190-15 related to falls prevention and management

Complaint 023902-16 related to oral care

Follow up 027826-15 CO #1 s. 6 (7)

Follow up 027827-15 CO #2 r. 36

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), registered nursing staff, personal support workers (PSW's), dietary staff, recreation staff, Resident Assessment Instrument (RAI) Co-ordinator and back-up, pharmacy staff, families and residents.

During the course of the inspection the inspectors toured the home, conducted interviews, observed the provision of care and services, reviewed relevant records including meeting minutes, policies and procedures, staffing schedules, and resident health records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
6 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #002	2015_337581_0014	156
LTCHA, 2007 s. 6. (7)	CO #001	2015_337581_0014	123

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

s. 6. (10) 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,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A) The record of resident #001 was reviewed and according to the January 2016 MDS assessment, the resident required one person, extensive assistance for toileting. The resident's January 2016 care plan was reviewed and activities of daily living (ADL) for toileting interventions noted that the resident required two staff, extensive assistance. The Resident Assessment Instrument (RAI) Coordinator was interviewed and confirmed that the resident's plan of care related to toileting was not based on the assessment of the resident and the resident's needs and preferences.

B) The quarterly MDS assessment dated May 2016 indicated that resident #002 was assessed as requiring extensive assistance and a two person physical assist. The DOC confirmed that the plan of care was not based on the assessment of the resident in terms of transfers as the plan of care in place at the time of the quarterly

MDS assessment did not include direction for transfers for this resident.

C) The record of resident #040 was reviewed including progress notes, care plan and kardex. It was noted in the resident's record on an identified date in August 2016 the resident did not need an identified falls intervention.
The resident's hard copy kardex was reviewed and included several falls interventions.
The DOC was interviewed and confirmed that as documented in the progress notes on August 2016 the resident did not need one of the interventions identified.
The resident's care plan was changed in August 2016; however, the kardex was not updated to reflect that this intervention was no longer used.
The licensee failed to ensure that the plan of care of resident #040 was based on an assessment of their needs and preferences.

D) Resident #041 was observed with adaptive aides. The resident's record was reviewed and care plan included: Risk for Impaired Skin Integrity - reoccurring skin tears due to fragile skin initiate on an identified date in September 2015 and revised on an identified date in August 2016. Interventions included: ensure adaptive aide in place; staff to be very careful and gentle during transfers and care interactions: skin fragile. The kardex was reviewed and it did not include information related to actual/potential alteration of skin integrity. The resident’s care plan and kardex were reviewed and they did not contain any information related to actual and or potential alteration in skin integrity. The DOC was interviewed and confirmed that the kardex did not include any information related to the residents actual/potential alteration in skin integrity. [s. 6. (2)]

2. The licensee failed to ensure that the resident, the resident’s substitute decision maker, if any, and other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The resident was assessed at that time but there was no injury as a result of the fall. The substitute decision maker (SDM) was notified via voice mail of the resident’s fall and status at the time. The Administrator reported that the expectation would be that the SDM was called again to confirm that they had received the message and/or that the second contact be contacted. At the time of the fall, the resident was a one-person extensive physical assistance for transfers. The resident initially denied pain,

however, later that day, the resident experienced pain and the area was noted by registered staff #121 to be tender, warm and swollen. The resident was given pain medication and was transferred using a lift. The SDM was not given opportunity to participate in the plan of care for the resident as the SDM was not informed of the resident's change in status related to pain, medication, and transfer using the lift as confirmed with registered staff #121.

The following day in November 2015, the resident was noted to be transferred using a mechanical lift and was experiencing pain as documented by registered staff #121. The SDM was not notified of the change in the resident's status regarding a more dependent lift being used and the resident's pain as confirmed during interview with registered staff #121.

A few days after the initial incident in November 2015, resident was noted to be experiencing pain and was given pain medication. The resident was assessed by the medical director and given additional pain medication shortly thereafter. The resident was transferred to hospital. The SDM was not notified of the change in the resident's pain, the administration of the new medication or the resident's transfer to hospital as confirmed with the Administrator.

The SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care as confirmed with the Administrator and registered staff #121. [s. 6. (5)]

3. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

A) The plan of care for resident #002 indicated that the resident was frequently incontinent of bladder and to toilet the resident when the resident gets up in the morning, before lunch, dinner and the evening and nights check as needed (PRN) on rounds. The plan indicated that the resident wore a brief and to change when wet. A review of the progress notes indicated on an identified date in April 2016 that the resident would have a pull up in the daytime and a brief at night. Interview with the resident and staff #104 reported that the resident wore a brief during the night and a pull up during the day. Both the resident and staff reported that that the resident toileted independently during the day. Interview with the Administrator confirmed that the plan of care was not reviewed and revised when the resident's

care needs had changed with regards to the continence products used or the resident's level of independence with regards to continence.

B) Resident #052 was noted to have had a fall on an identified date in July 2015. A review of the progress notes indicated that the resident had an identified falls intervention in place at the time of the fall. The care plan in effect at the time of this fall did not include the falls interventions to prevent a fall. Interview with the DOC confirmed that the care needs had changed and the plan of care in place at the time of the fall should have included the falls intervention for the resident.

C) On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. At the time of the fall, the resident was a one-person extensive physical assistance for transfers. The resident initially denied pain, however, later that day, the resident experienced pain and was transferred using a lift. The following day, the resident was transferred using a mechanical lift. The resident’s care needs had changed, however, the plan of care was not revised to include the change in transfers as confirmed with the Administrator. [s. 6. (10) (b)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

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 plans of care are based on an assessment of the residents and the resident's needs and preferences, to be implemented voluntarily.

WN #2: 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 :

(A2)
1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A) The home policy Oral Assessment and Care last updated June 2016 indicated that care staff were to provide residents with mouth care, as per resident's care plan, twice per day and more often as required. Oral care included "cleaning and flossing of teeth, cleaning of the gums and tongue, and denture cleaning if applicable".
The plan of care for resident #051 indicated that staff were to floss the resident's teeth after each meal. The resident reported that not all staff would complete this aspect of care, however, during the dates observed, the resident's teeth were flossed.
Interview with the DOC confirmed that the oral care policy was not complied with as resident #051 was the only one in the home that received flossing of teeth.

B) The home's policy and procedures related to an identified medical condition was reviewed and included directions for treatment.

The record of resident #044 was reviewed. The progress notes on an identified date in January 2016 included that the resident showed symptoms of the identified medical condition. The resident was assessed for the condition and treatment was given; however, documentation indicated that the staff did not follow the step by step directions in the policy. The DOC was interviewed and confirmed that the staff did not follow the home's policies and procedures related to the identified medical

condition.

C) The home policy for Pain policy 05-08-01 dated April 2010 indicated that residents who express new pain or an exacerbation of existing pain will have a pain assessment completed at the time of pain expression. Each time an as needed (PRN) pain medication is given staff were to complete the Pain Flow Sheet prior to the administration of the PRN pain medication and then again 30 minutes to 1 hour after the medication administration. For cognitively well residents the numeric scale was to be used; for cognitively impaired residents the faces scale was to be used.

i) On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The resident initially denied pain, however, later that day, the resident experienced pain; the area was noted by registered staff #121 to be tender, warm and swollen. The resident was given pain medication, however the Pain Flow Sheet was not completed prior to the administration of the PRN pain medication and then again 30 minutes to 1 hour after the medication administration as per policy and confirmed during interview with the Administrator.

ii) The Falls Prevention and Management policy of the home updated May 2016 but confirmed with the Administrator to be in place at the time of the fall included a Clinical Monitoring Record where the following were to be monitored every hour x 4 hours and then every 8 hours for 72 hours post fall: neurovital signs (if head, brain injury suspected or the fall is unwitnessed), monitor vital signs, assess for pain, monitor for changes in behaviour.

On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The Clinical Monitoring Record was started. The pain was monitored and documented at the time of the fall but then not again until several hours later. Temperature, pulse, blood pressure, respiration and oxygen was not recorded as being taken until the evening shift. Interview with registered staff #124 confirmed that the resident was not monitored for pain, vitals were not taken and recorded once per hour for the first four hours post fall as per policy.

D) The home's policy and procedures Drug Destruction and Disposal, number 5-4, dated January 2014 was indicated "Both nurses will be accountable to complete and double sign medication onto Drug Destruction and Disposal form and place the

medication into a locked monitored drug storage (i.e. wooden box) until drug destruction takes place".

The home's records including Critical Incident notification were reviewed. It indicated that on an identified date in May 2016 during routine drug destruction with the pharmacist, it was noted that eight Tylenol number two tablets were unaccounted for. The home's record noted that on an identified date in March 2016 two nurses signed the form without seeing the actual card of narcotics to confirm that they were present. The Administrator was interviewed and confirmed that the staff signed the form without seeing and placing the medication into the drug destruction box as per the home's policies and procedures.

E) Random audits were conducted of the home's Narcotic Ward Count records; Monitored Medication Records for Seven-Day Cards and Individual Monitored Medication Records and missing and or incomplete documentation was noted. The Charge Nurse and the DOC were interviewed and they confirmed the missing and incomplete documentation in the above records. They also confirmed that the documentation of narcotic medications was not completed as per the home's policies and procedures. [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A) The home's Resident Abuse, Resident Rights and Commitment to Residents policy dated April 2016 under Jurisdictional Reporting Requirements indicated "Mandatory reporting under the LTCHA (Ontario) requires a person to make an immediate report to the Director where there is a reasonable suspicion that certain incidents occurred or may occur. The LTCHA provides that any person who has reasonable grounds to suspect that any of the following has occurred, or may occur must immediately report the suspicion and information which is based to the Director of the Ministry of Health and Long Term Care: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident".

According to the progress notes for resident #002 on an identified date in May 2016, staff noted that the resident was bruised and that the resident stated that the staff who got them up in the morning grabbed them pulling too hard causing the bruise. Progress notes suggested there were reasonable grounds to suspect abuse to resident #002.
Interview with the Administrator confirmed that the incident of alleged abuse was not reported to the Director as required.

B) The home's policy, Zero Tolerance of Resident Abuse and Neglect: Response and Reporting #RC-02-01-02 Last Updated: April 2016 was reviewed and it included: "All staff / persons involved with Extendicare homes have a duty to report any form of alleged, potential, suspected or witnessed abuse, including suspected abuse outside the home".

The home's records were reviewed and it was noted that on an identified date in April 2016 resident #041 that the resident was observed crying, with two skin tears The resident told the PSW that the staff grabbed them. The PSW informed the registered staff of the resident's wounds and not the statements of the resident. The DOC was interviewed and confirmed that the staff did not immediately report the alleged abuse as per the home's policy and procedures. [s. 20. (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 there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The resident initially denied pain, however, later that day, the resident experienced pain; the area was noted by registered staff #121 to be tender, warm and swollen. The resident was given PRN pain medication.

The following day in November 2015, the resident was noted to be transferred using a mechanical lift and was experiencing pain as confirmed with registered staff #121. The resident’s pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose as confirmed during interview with registered staff #121 and with the Administrator. [s. 52. (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 a resident’s pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A) The record of resident #040 was reviewed including the October 2015 Medication Administration Record (MAR). It was noted that the resident was to receive a medication by mouth at bedtime. The review of the MAR indicated that the medication was not available.
The home's records including CI report were reviewed and it was noted that resident #040 did not receive the medication for three days as it was not available and was transferred to hospital on an identified date in October 2015 due to a medical condition.
The DOC was interviewed and confirmed that the medication was not administered to resident #040 in accordance with directions for use specified by the prescriber.

B) The record of resident #044 was reviewed including the December 2015 MAR and it was noted that they were to receive a medication once daily in the evening at dinner.
The home's records including criitial incident (CI) report were reviewed and the documentation indicated that on an identified date in December 2015 resident #044 was given the wrong dose of the medication. The physician was contacted and the resident was taken to hospital as a result. The DOC was interviewed and they confirmed that the medication was not administered to the resident #044 in accordance with the directions for use specified by the perscriber. [s. 131. (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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents’ drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident’s drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident taking any drug or combination of drugs, including psychotropic drugs, there was a monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The resident initially denied pain, however, later that day, the resident experienced pain; the area was noted by registered staff #121 to be tender, warm and swollen. The resident was given PRN pain medication; however, the resident was not monitored and their response and the effectiveness of the medication was not documented as confirmed with registered staff #121. [s. 134. (a)]

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 for the resident taking any drug or combination of drugs, including psychotropic drugs, there was a monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #7: 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), (3) or (3.1) 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:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) 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: 3. Actions taken in response to the incident, including the outcome or current status of the individual or individuals who were involved in the incident.

Resident #050 was noted to have had a fall on an identified date in June 2015 which resulted in transfer to hospital. A Critical Incident was submitted by the home to the Director and an amendment was requested. Actions were not taken in response to the outcome or current status of the individual who was involved in the incident. No response was received from the home regarding the amendment as confirmed with the DOC and Administrator. [s. 107. (4) 3. v.]

Issued on this 23 day of February 2017 (A2)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CAROL POLCZ (156) - (A2)

Inspection No. / No de l'inspection : 2016_322156_0010 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 023985-16 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Feb 23, 2017;(A2)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE HAMILTON
90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Pilar Henderson

To EXTENDICARE (CANADA) 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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

(A2)
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.

Grounds / Motifs :

(A1)
1. The order is made up on the application of the factors of severity (3), scope (1), and compliance history (3), in keeping with s. 6 (5) of the Act, in respect to the actual harm for resident #053, the scope of this being an isolated issue in the home, and the licensee's history of non-compliance with a VPC issued in July 2015 during the RQI inspection for s. 6.

The licensee failed to ensure that the resident, the resident's substitute decision maker, if any, and other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date in November 2015, resident #053 had a controlled fall while standing in the bathroom with PSW #120. The resident was assessed at that time but there was no injury as a result of the fall. The SDM was notified via voice mail of the resident's fall and status at the time. The Administrator reported that the expectation would be that the SDM was called again to confirm that they had received the message and/or that the second contact be contacted. At the time of the fall, the resident was a one-person extensive physical assistance for transfers. The resident initially denied pain, however, later that day, the resident experienced pain; the area was noted by registered staff #121 to be tender, warm and swollen. The resident was given PRN pain medication and was transferred using a lift. The SDM was not given opportunity to participate in the plan of care for the resident as the SDM was not informed of the resident's change in status related to pain, medication, and transfer using the lift as confirmed with registered staff #121.

The following day in November 2015, the resident was noted to be transferred using a mechanical lift and was experiencing pain as documented by registered staff #121. The SDM was not notified of the change in the resident's status regarding a more dependent lift being used and the resident's pain as confirmed during interview with registered staff #121.

A few days after the initial incident in November 2015, resident was noted to be experiencing pain and was given pain medication. The resident was assessed by the medical director and given additional pain medication shortly thereafter. The resident was transferred to hospital. The SDM was not notified of the change in the resident's pain, the administration of the new medication or the resident's transfer to hospital as confirmed with the Administrator.

The SDM was not given an opportunity to participate fully in the development and implementation of the resident's plan of care as confirmed with the Administrator and registered staff #121.

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

Oct 15, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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 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

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
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.

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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
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 23 day of February 2017 (A2)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : CAROL POLCZ - (A2)

Service Area Office / Bureau régional de services : Hamilton