

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

Hamilton Service Area Office 119 King Street West, 11th Floor HAMILTON, ON, L8P-4Y7 Telephone: (905) 546-8294 Facsimile: (905) 546-8255 Bureau régional de services de Hamilton 119, rue King Ouest, 11iém étage HAMILTON, ON, L8P-4Y7 Téléphone: (905) 546-8294 Télécopieur: (905) 546-8255

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Date(s) of inspection/Date(s) de Inspection No/ No de l'inspection d'inspection/Genre d'inspection/Aug 26, Sep 20, 2011 2011_026147_0014 Complaint

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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistance Director of Care (ADOC), Business Manager, Physiotherapist Assistant, Staff and Residents.

During the course of the inspection, the inspector(s) interviewed the Administrator, Assistance Director of Care and the physiotherapist assistant, reviewed clinical chart and progress notes, reviewed Policy and Procedure related to Resident Safety and abuse and neglect.

H-000721-11

The following Inspection Protocols were used during this inspection:

Admission Process

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES



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Legend	Legendé		
WN - Written Notification	WN – Avis écrit VPC – Plan de redressement volontaire		
VPC - Voluntary Plan of Correction DR - Director Referral	DR – Alguillage au directeur		
CO – Compliance Order WAO – Work and Activity Order	CO – Ordre de conformité WAO – Ordres : travaux et activités		
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 3. Residents' Bill of Rights



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Specifically failed to comply with the following subsections:

- s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
- 1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
- 2. Every resident has the right to be protected from abuse.
- 3. Every resident has the right not to be neglected by the licensee or staff.
- 4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
- 5. Every resident has the right to live in a safe and clean environment.
- 6. Every resident has the right to exercise the rights of a citizen.
- 7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
- 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
- 9. Every resident has the right to have his or her participation in decision-making respected.
- 10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
- 11. Every resident has the right to,
- i. participate fully in the development, implementation, review and revision of his or her plan of care,
- ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
- iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
- iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
- 12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
- 13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
- 14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
- 15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
- 16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
- 17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
- i. the Residents' Council,
- ii. the Family Council,
- iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
- iv. staff members,
- v. government officials,
- vi. any other person inside or outside the long-term care home.
- 18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
- 19. Every resident has the right to have his or her lifestyle and choices respected.
- 20. Every resident has the right to participate in the Residents' Council.
- 21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.



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22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants:

1. An identified resident was transferred to hospital due decline in health condition for further assessment. However, the home failed to immediately inform the resident's substitute decision maker regarding the transfer and hospitalization of the resident.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents Specifically failed to comply with the following subsections:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits saillants:

An identified resident had a decline in health condition for a suspected serious illness. The resident was subsequently sent to hospital for further assessment. The home failed to promptly notify the resident's designate promptly related to resident's serious illness.

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 all resident's designate are promptly informed related to any serious illness, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 82. Attending physician or RN (EC) Specifically failed to comply with the following subsections:

s. 82. (2) The resident or the resident's substitute decision-maker may retain a physician or registered nurse in the extended class to perform the services required under subsection (1). O. Reg. 79/10, s. 82 (2).

Findings/Faits saillants:

1. Two identified residents were admitted to the home in 2011. At the time of admission both residents and family members requested for the home to ensure the continuity of care be respected related to having the resident's family physician continue to provide care for both residents while in the home. However, the request was not initiated until later in 2011.



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Issued on this 19th day of October, 2011

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Signature of Inspector(s)/Signature de l'inspecteur ou de	es inspecteurs	•
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D. Mill	•	