Ontario

**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 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**

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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| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 4, 2013 | 2013_214146_0050 | H-000464-13 | 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**

BARBARA NAYKALYK-HUNT (146), TAMMY SZYMANOWSKI (165)

**Inspection Summary/Résumé de l'inspection**

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

This inspection was conducted on the following date(s): September 19, 20, 23, 24, 25, 2013

This inspection was conducted concurrently with complaint inspection H-000185 -13 and critical incident inspection H-000209-13. Non-compliance related to s.6 (7) from H-000209-13 is included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Resident Assessment Instrument(RAI) back-up, Medical Director, registered staff, Personal Support Workers (PSW's), dietary aides, residents and family members.

During the course of the inspection, the inspector(s) reviewed policies and procedures related to continence care, pain management, nurse call system, falls prevention and management, personal hygiene/grooming; reviewed the home's complaint log for 2013; observed residents and staff in the dining room; observed care of residents; observed bed/chair alarm systems in operation; and reviewed resident health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
(a)The diet serving list indicated that resident #003 was not to be served a specific food, however during a lunch meal in September 2013, the resident received the specified food.
(b) The dental status plan of care for resident #003 indicated that staff would assist the resident to brush teeth post breakfast, lunch and supper; however, the resident was observed leaving the home area after breakfast in September 2013, without having received assistance to brush teeth. The resident's toothbrush was noted to be dry. Staff confirmed that the resident's teeth were not brushed after breakfast.
(c) The plan of care for falls risk for resident #003 directed staff that a chair alarm was to be on at all times when up in chair. Resident #003 was observed in a wheelchair in September 2013 self-propelling in the hallway. The chair alarm was attached to the resident but did not activate when tested by removing the chair end of the cord from the battery box. The staff confirmed that the batteries needed changing.
(d) The plan of care for falls risk for resident #100 directed staff that a chair alarm was to be on at all times when up in chair. In September 2013, when tested by the inspector when the resident was in a wheelchair, the chair alarm was not working and needed new batteries.
(e)The plan of care for falls risk for resident #001 directed staff that the resident was to have a specified falls management intervention. In April 2013, resident #001 fell and sustained injury. The health record and DOC confirmed that the intervention was not in place as per the plan of care.
(f) The plan of care for falls risk for resident #001 directed staff that a bed or chair alarm was to be attached to the resident when in bed or in the chair. In June 2013, while resting in bed the resident fell onto the floor without injury. No bed alarm was in place.
(g)The plan of care for falls risk for resident #200 directed staff to have a chair alarm in place when up in chair. In September 2013, resident #200 was observed self-propelling in the hallway. The chair alarm was attached to the back of the chair but not to the resident.
All of the above were confirmed by observation, review of health records and by the DOC. [s. 6. (7)]

***Additional Required Actions:***

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

**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**
**Specifically failed to comply with the following:**

**s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).**

**Findings/Faits saillants :**

1. The licensee of the long term care home did not ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.
a) Documented flow sheets for resident #003 indicated the resident only received one bath per week for a week in August 2013. The flow sheets indicated that there were no baths provided for another week in August 2013. The DOC confirmed that there should have been two baths provided during the identified time period.
b) Documented flow sheets for resident #004 indicated that the resident only received one bath per week for two weeks in September 2013.
c) Documented flow sheets for resident #005 indicated that the resident only received one bath per week for two weeks in September 2013.
The DOC confirmed that if a resident refused a bath that this was recorded on the flow sheets however; there were no refusals documented for resident #003, #004 and #005 during this time period. [s. 33. (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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident`s hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.***

**Issued on this 4th day of October, 2013**

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

Ontario

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

Ministére 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

**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**

**Public Copy/Copie du public**

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | BARBARA NAYKALYK-HUNT (146), TAMMY SZYMANOWSKI (165) |
| **Inspection No. / No de l'inspection :** | 2013_214146_0050 |
| **Log No. / Registre no:** | H-000464-13 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Oct 4, 2013 |
| **Licensee / Titulaire de permis :** | EXTENDICARE (CANADA) INC.<br>3000 STEELES AVENUE EAST, SUITE 700,<br>MARKHAM, ON, L3R-9W2 |
| **LTC Home / Foyer de SLD :** | EXTENDICARE HAMILTON<br>90 CHEDMAC DRIVE, HAMILTON, ON, L9C-7S6 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Joan Blunt |

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.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

**Order / Ordre :**

The licensee shall prepare, submit and implement a plan demonstrating how the home will ensure that care set out in the plan of care is provided to the resident as specified in the plan. The plan shall be submitted electronically to Barb Naykalyk-Hunt, LTC Homes Inspector, Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, Hamilton Service Area Office at Barbara.Naykalyk-Hunt@ontario.ca by the end of business day October 25, 2013.

**Grounds / Motifs :**

1. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.
(a) The diet serving list indicated that the resident #003 was not to be served a specified food, however, during a lunch meal in September 2013, the resident received the specified food.
(b) The dental status plan of care for resident #003 indicated that staff would assist the resident to brush own teeth post breakfast, lunch and supper; however, the resident was observed leaving the home area after breakfast in September 2013, without having received assistance to brush teeth. The resident's toothbrush was noted to be dry and staff confirmed that the resident's teeth were not brushed after breakfast.
(c) The plan of care for falls risk for resident #003 directed staff that a chair alarm was to be on at all times when up in chair. Resident #003 was observed in a wheelchair in September 2013 self-propelling in the hallway. The chair alarm was attached to the resident but did not activate when tested by removing the chair end of the cord from the battery box. The staff confirmed that the batteries needed changing.

(d) The plan of care for falls risk for resident #100 directed staff that a chair alarm was to be on at all times when up in chair. In September 2013, when tested by the inspector when the resident was in a wheelchair, the chair alarm was not working and needed new batteries.
(e) The plan of care for falls risk for resident #001 directed staff that the resident was to have a specific falls management intervention. In April 2013, resident #001 fell and sustained an injury. The intervention was not in place as per the plan of care.
(f) The plan of care for falls risk for resident #001 directed staff that a bed or chair alarm was to be attached to the resident when in bed or in the chair. In June 2013, while resting in bed the resident fell onto the floor without injury. No bed alarm was in place.
(g) The plan of care for falls risk for resident #200 directs staff to have a chair alarm in place when up in chair. In September 2013, resident #200 was observed self-propelling in the hallway. The chair alarm was attached to the back of the chair but not to the resident.
All of the above were confirmed by observation, review of health records and also confirmed by the DOC.
Section 6(7) was issued previously on 2011/11/15 as a VPC and WN. (165)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 25, 2013

## 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
Performance Improvement and Compliance 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

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

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 4th day of October, 2013**

**Signature of Inspector / Signature de l'inspecteur :** B NAYKALYK-HUNT

**Name of Inspector / Nom de l'inspecteur :** BARBARA NAYKALYK-HUNT

**Service Area Office / Bureau régional de services :** Hamilton Service Area Office