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

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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
Sep 19, 2014	2014_288549_0035	O-000714-14,O-000920-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE MEDEX
1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 15, 16, 17, 18, 19, 2014

Log # O-000714-14 and Log # O-000920-14

During the course of the inspection, the inspector(s) spoke with several Residents, several Registered Nurses(RN), several Registered Practical Nurses (RPN), a Physiotherapist, several Personal Support Workers(PSW), a Social Worker, the Director of Care, the Assistant Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed several resident health care records, a capacity assessment, the nursing schedule for a specified period of time and observed resident care being provided.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee has failed to ensure that Resident #2's plan of care was reviewed and revised when the resident's care needs changed.

A review of the health care records for Resident #2 indicated that the resident returned from hospital on a specified day.

During an interview with PSW #S103 it was indicated to Inspector #549 that the 2 person transfer process for Resident #2 is completed using a specific technique due to the change in the resident's health care needs. There is no documentation in the plan of care indicating this transfer technique is to be used for transferring Resident #2.

PSW #S103 indicated that Resident #2's medical device is to be applied in a specific manner and that it is important to apply the medical device correctly for the resident's comfort and to promote healing. This is a change in care needs for Resident #2. There is no documentation in the plan of care describing the procedure for the Personal Support Workers to follow for the application of the resident's medical device .

During an interview with RPN #S105 and the Director of Care it was indicated to Inspector #549 that the resident was not reassessed and the plan of care had not been reviewed and revised to reflect the care need changes for Resident #2 related to the transfer procedure or the application of the medical device.

The plan of care states that Resident #2 will receive Range of Motion (ROM) exercises for upper and lower body 2x10reps/1set with light manual resistance. The physiotherapist confirmed to Inspector #549 that Resident #2 does not receive ROM exercises for a specified body part at the present time due to the application of the medical device.

During an interview with the physiotherapist it was indicated to Inspector #549 that Resident #2 was not reassessed and the plan of care reviewed and revised to reflect the care need changes for Resident #2 related to the ROM exercises.

The Director of Care indicated to Inspector #549 that the home's expectation is that Resident #2 would be reassessed upon return from the hospital and the plan of care be reviewed and revised as required to meet the change in the care needs of the resident. [s. 6. (10) (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 Resident #2 is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, interventions and the resident's responses to the interventions are documented.

The home is required to have a pain management program to meet the needs of the resident. O.Reg 79/10,s.48 (1) 4.

During an interview with RPN #S100 it was indicated to Inspector #549 that on a specified day PSW #S102 reported to RPN #S100 that Resident #2 was expressing symptoms of pain when touched during morning care and that the resident's body alignment looked unusual. Resident #2 is cognitively impaired with limited communication abilities.

RPN #S100 indicated that he/she went to Resident #2's room and assessed the resident. RPN #S100 indicated that the resident was not expressing any symptoms of pain at that time and did not see any unusual changes in Resident#2's body alignment.

On the same day Resident #2's family member requested that PSW S#107 page the Charge RN to assess Resident #2's pain and unusual body alignment.

During an interview RN S#101 indicated to Inspector #549 that he/she came to the unit and assessed Resident #2 for pain and the resident's unusual body alignment. RN #101 stated from his/her assessment the decision was made to send Resident #2 to the hospital for further assessment.

During an interview with the DOC it was indicated to Inspector #549 that the documentation of the assessments, interventions and Resident #2's response to the interventions completed by the registered staff for Resident #2 related to pain and the unusual body alignment would be located in the resident's electronic health record.

Resident #2 was assessed twice on a specified day by a registered staff member for pain and the unusual body alignment.

On September 17, 2014 Inspector #549 reviewed the electronic health record for Resident #2. The assessments, interventions or Resident #2's response to interventions were not documented in the resident's electronic health record related to the resident's pain or the unusual body alignment. [s. 30. (2)]

WN #3: 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. (3) 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. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director be informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

Resident #2’s had a significant change in health condition which required a transfer to hospital on specified day. The resident returned to the home on a specified day with a significant change in health condition.

During an interview with RPN #S105 and RN #S104 it was indicated to Inspector #549 that their understanding of the home’s expectation is to report all significant changes in a resident’s health condition that requires a transfer to the hospital to the home's Administration so the Director can be informed.

During an interview the Administrator and Director of Care confirmed to Inspector #549 that the home’s expectation is that the injury to Resident #2 should have been reported as an unusual occurrence due to the significant change in health condition and reported to Administration so the Director can be informed using Ministry of Health and Long Term Care Critical Incident System.

The Director of Care and Administrator indicated to Inspector #549 that they became aware of the significant change in the health condition of Resident #2 for which the resident was sent to hospital on a specified day. In discussion with the Administrator and Director of Care on September 19, 2014 the Director has not been informed. [s. 107. (3) 4.]

Issued on this 3rd day of October, 2014

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