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
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 21, 2015	2014_289550_0030	O-001104-14	Critical Incident System

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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 10 and 12, 2014.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a registered practical nurse (RPN), a Personal Support Worker (PSW) and a Resident.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident are identified, where possible; (b) strategies are developed and implemented to respond to these behaviours, where possible; and (c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

Resident #002 was admitted to the home on a specific date in March 2014 with four specific diagnoses. On a specific day in October 2014 Resident #002 was sitting at his/her chair in the dining room at suppertime. Resident #001 was walking in the dining room towards his/her own chair holding himself/herself onto the back of other chairs along the way for balance. When Resident #001 put his/her hand on the back of Resident #002's chair, Resident #002 got up and with his/her fist hit Resident #001 several times. Resident #001 fell to the floor and Resident #002 fell on top of him/her which resulted in Resident #001 having multiple fractures of 2 specific body parts.

On November 10, 2014 the Director of Care indicated to Inspector #550 during an interview that Resident #002 is very protective of his/her personal space and that this was possibly the reason the resident became physically aggressive towards Resident #001 because he/she grabbed Resident #002's chair.

During an interview on November 12, 2014, RPN #S100 indicated to the Inspector the resident becomes easily frustrated and agitated when there are changes in his/her routine and if people get too close to his/her environmental space as he/she is very

protective of it.

During an interview on November 12, 2014, PSW #S101 indicated to the Inspector that she has known the resident for a long time. She indicated the resident is not usually physically aggressive but becomes easily agitated and verbally aggressive because of his/her hearing impairment and that he/she is very protective of his/her own space.

Inspector #550 reviewed Resident #002's behavioural plan of care and was unable to find documentation of the behavioural triggers, the strategies to respond to the behaviour and the action taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented for this resident regarding his/her physical aggression.

On November 12, 2014, the Director of Care indicated to Inspector #550 she was unable to find documentation of the identification of the behavioural triggers, the strategies and interventions for Resident #002's aggressive behaviour and that it should have been indicated in Resident #002’s plan of care.

Inspector #550 reviewed the home’s Responsive Behaviour policy #09-05-01 dated September 2010. The policy indicates on page 1 paragraph 2 that ‘’Each resident displaying the responsive behaviours will have this behaviours observed and assessed. A resident focused care plan will be developed and maintained that includes: Triggers to the behaviours’’.

The licensee did not ensure that the behavioural triggers for Resident #002 are identified, strategies are developed and implemented to respond to these behaviours and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident’s responses to interventions are documented. [s. 53. (4)]

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 #002's behavioural triggers are identified, strategies are developed and implemented and actions are taken to respond to Resident #002's needs, to be implemented voluntarily.

Issued on this 22nd day of January, 2015

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

Original report signed by the inspector.