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
Jan 8, 2014	2013_295556_0003	O-001170-13	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

WENDY PATTERSON (556)

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): January 2-3, 2014 onsite

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Support Services Manager, two Registered Nurses (RN), three Registered Practical Nurses (RPN), three Personal Support Workers (PSW), one resident, and two Behaviour Supports Ontario (BSO) Champions.

During the course of the inspection, the inspector(s) reviewed the homes abuse and responsive behaviour policies, two residents' health records, and observed care and services given to residents.

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

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 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 :

1. The Ontario Regulation 79/10, s.55. (a) states that every licensee of a long-term care home shall ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A review of a Critical Incident Report submitted by the home to the Ministry of Health and Long Term Care indicates that on a specified date Resident #2 was sitting outside the dining room when Resident #1 walked up and struck Resident #2 resulting in an injury to resident #2. The progress notes in Resident #1's medical record indicate that the incident was unprovoked and was witnessed by an RPN, and a visitor to the home.

Inspector #556 reviewed the home's policy entitled Evaluation / Analysis of Aggressive Incident Document # RESI-09-05-12, implemented December 2002, reviewed December 2002. The ADOC provided the policy and the DOC stated that this is the policy the home is using. The policy indicates that a debriefing session should occur immediately following the resolution of an aggressive incident if a resident has been injured in the incident.

The DOC provided Inspector #556 with a copy of the tool that is to be used to document the debriefing session. The tool is attached to the policy and an electronic version is located in Point Click Care (PCC), the electronic documentation system used by the home, and is called Responsive Behaviour Debrief Tool.

Inspector #556 reviewed Resident #1's medical record and there was no completed Responsive Behaviour Debrief on file for the incident. The DOC stated that following the incident the RN opened the Responsive Behaviour Debrief Tool for Resident #1 but did not complete it.

As such the licensee failed to comply with O.Reg 79/10, s. 8 (1) (b) in that they did not ensure that procedures in the home's policy entitled Evaluation / Analysis of Aggressive Incident were complied with as required under O. Reg 79/10, s. 55. (a). [s. 8. (1) (a),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 required policies related to responsive behaviours are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The above mentioned Critical Incident Report states that on a specified date Resident #2 was sitting outside the dining room when Resident #1 walked up and struck Resident #2 resulting in an injury to Resident #2.

Inspector #556 reviewed the progress notes in Resident #1's medical record for the incident which indicate that the incident was witnessed by an RPN and a visitor to the home; that Resident #2 sustained an injury; and that Resident #2 was transferred to the hospital for assessment. The progress notes also indicate that the incident was reported to the DOC via voice mail on the day the incident occurred.

Inspector #556 interviewed the DOC who stated that an email was sent to the MOH one day after the incident to report the incident between Resident #1 and Resident #2. A copy of the email was provided by the DOC.

A review of the Critical Incident Report indicates the Critical Incident Report was submitted by the home to the Ministry of Health and Long Term Care two days after the incident. As such the licensee failed to report an incident of resident to resident abuse immediately to the Director [s. 24. (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 any person who has reasonable grounds to suspect abuse of a resident by anyone shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 8th day of January, 2014

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