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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jun 14, 2016	2016_286547_0012	002451-16	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 MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

LISA KLUKE (547)

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): April 28, 29, May 2, May 9, 2016

This inspection has been initiated as a result of the following complaints and critical incidents:
-Complaint IL-42585-OT in regards to a fall resident #001 had in October 2015 in the home that resulted in a fracture.
-Critical incident #2579-000021-15 was reported by the home regarding this incident that caused an injury to the resident for which the resident was taken to hospital and resulted in significant change the resident's health status.
-Complaint log # IL-44443-OT in regards to care of resident #001 after becoming unresponsive and required oxygen administration to increase resident #001's saturation levels for unknown reason.
-Critical Incident #2579-000008-16 was reported by the home regarding this incident the home identified as improper/incompetent treatment of resident #001.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents and a family member.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 #001 was reassessed and the plan of care reviewed and revised when resident #001's care needs changed after a fall while trying to transfer into bed and sustaining a fracture.

This is related to complaint log #002451-16 and CI #2579-000021-15 reported by the home on a specified date in October, 2015 in regards to a fall resident #001 had in the home that resulted in a fracture.

Resident #001 was admitted to the home on a specified date in 2012 with several complex medical diagnoses and was assessed as high risk of falls by the home on a specified date in 2013. The resident had a history of two unwitnessed falls in 2014 and once in 2015 prior to this incident in October 2015 whereby each fall occurred in the resident's bedroom at the resident's bedside. Resident #001 requires mechanical lift for transfers since admission to the home related to non-weight bearing capacity.

On this specified date in October 2015, resident #001 was found on the floor in the resident's bedroom at the resident's bedside in the evening. Resident #001's post-fall assessment for this incident indicated the resident attempted to transfer self to bed. The resident's substitute decision maker (SDM) stated upon return from the hospital "that resident #001 was tired and had pain and was trying to get into bed before the fall occurred."

Inspector #547 reviewed the resident health records and noted that the resident was

assessed by the evening charge RN#100 after the resident's fall on the evening shift and then mechanically transferred into bed. RN #100 completed a post fall assessment and started a neurological flow sheet for this resident's unwitnessed fall starting at a specified time in the evening.

The DOC indicated to Inspector #547 that she noticed upon review of resident #001's fall on this specified date in October 2015 that there was no documentation of any other reassessments completed by the registered nursing staff for resident #001 from the post fall assessment completed by RN #100 at a specified time mid-evening and call placed to the resident's SDM regarding the resident's fall. The last documented assessment of this unwitnessed fall by any registered nursing staff was completed three hours after the fall occurred by the night shift (2230-0630 hours) with only a neurological assessment. The DOC indicated that the home would expect documentation in the progress notes as well as ongoing documented assessment of the resident after any fall on every shift.

Inspector #547 interviewed RPN #111 who worked on the day shift (0630-1430 hours) on the day following resident #001's fall. RPN #111 indicated she was informed during the shift report that resident #001 had a fall during the evening shift and to monitor a specified location on the resident’s lower body. PSW #106 asked RPN #111 at 0730 hours to go and assess another specified location of resident #001's lower body and not the location identified during the shift report. RPN #111 indicated that resident #001's specified location on the lower body was assessed and noted to be swollen and painful to touch as the resident stated " Oh -Oh" during palpitation of this body location. RPN #111 decided to call the home's nurse practitioner regarding the resident's condition. The home's nurse practitioner came to the home and assessed the resident and indicated to RPN #111 to send the resident to hospital for x-ray for possible fracture.

The resident was sent to hospital on this specified date fifteen hours after resident #001 fell. Resident #001 returned from hospital this same day diagnosed with fracture.

The registered nursing staff failed to re-assess resident #001 after a fall in the evening of a specified date in October 2015 extending the need to send the resident to hospital until fifteen hours later and diagnosed with fracture.

2. Secondly, the licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed on a specified date in April 2016 with an acute episode of illness.

This is related to complaint log # 002451-16 regarding care of the resident in the home and a critical incident reported by the home #2579-000008-16 they identified as improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

Based on interviews, record review of the resident health records, the sequence of events from this specified date in April 2016 was as follows:

- RPN #101 provided resident #001 medication and a supplement while seated in the doorway of the resident's bedroom. Resident was alert and oriented, smiling at RPN #101.

- PSW #104 and #105 provided resident #001's normal bedtime routine and transferred to bed with lift. PSW #105 indicated that resident #001 was assisting in changing into night clothing and was provided a washcloth to wash his/her face, when she left the room to assist PSW #104 with another resident. PSW #105 returned less than five minutes later and stated that "resident #001 was lying in bed, eyes closed, breathing funny like tummy breathing and not responding when spoken to". PSW #105 went to get PSW #104 to assess the resident and both PSW's tried to wake the resident.

- PSW #105 reported to RPN #101 and #103 working on the other wing of the floor that they needed to assess resident #001 as not responding suddenly after being transferred to bed.

- RPN #103 informed RPN #101 that she would go assess the resident. RPN #103 assessed the resident, indicated that resident #001 was breathing rapidly and not responding when she shook the resident's shoulder. RPN #103 then went and reported this to the Charge RN #100 and requested her to go and assess resident #001's condition.

- RN #100 and RPN #101 then went to assess resident #001 and completed the resident's vital signs and noted that the resident's oxygen saturation level was low and the resident was not responding when spoken to which RPN #101 indicated to RN #100 that "this was not like this resident". RN #100 instructed RPN #101 to continue with her assessment and she would go get an oxygen tank on another floor in the home. RN #100 returned five minutes later and no change in the resident, and provided the resident with three litres of oxygen via nasal prongs. RN #100 left and instructed RPN #101 to continue to monitor the resident. RPN #101 returned to resident #001's room less than 15 minutes later indicated the resident's responsiveness was unchanged but the oxygen

saturation level had increased a bit. RN #100 returned to resident #001's room at this time approximately 45 minutes after the resident was found unresponsive and decided to increase the resident's oxygen. RPN #101 asked RN #100 if they were going to send resident #001 to the hospital. RN #100 indicated that since all of the rest of the resident's vital signs were stable and the resident did not look in distress as appeared to be in a deep sleep that the resident did not need to go to the hospital at this time. RPN #101 indicated that she preferred to call the resident's Substitute Decision Maker (SDM) of this change in the resident's condition. RPN #101 called the resident's SDM approximately 70 minutes after the resident was found unresponsive on both home and cellular lines but was unable to reach the SDM.

-RPN #101 provided night charge RN #102 report of the first floor at approximately 2220 hours including resident #001's health condition, and that she thought resident #001 should be sent to the hospital. RN #102 indicated that he would assess the resident after he received all the floors shift reports. RPN #101 indicated to Inspector #547 that they follow the decisions of the charge RN's in the home as per the home's process.

-RN #100 provided RN #102 shift report at 2230 hours and indicated that resident #001 required monitoring as the resident was not responding as usual and required oxygen via nasal prongs for low oxygen saturation suddenly for no apparent reason. RN #100 indicated to Inspector #547 that "when she provided report to RN #102 that she realized that she should have sent resident #001 to hospital with these symptoms." RN #100 further stated that she "offered RN #102 assistance to prepare and send the resident to the hospital before she left to go home, but RN #102 indicated that he had it covered."

-RN #102 proceeded to receive the other floor shift reports. RN #102 stated to Inspector #547 " that he did not think resident #001 was in any distress and was provided oxygen based on saturation levels from the reports provided to him from RPN #101 and RN #100 on the evening shift."

- Resident #001's SDM arrived to the home at approximately almost two and a half hours after the resident became unresponsive as two attempts had been made by the home to reach the SDM that evening. The resident's SDM went to resident #001's room and noted the resident was not breathing well and not responding when spoken to. The SDM left the resident's room asking for assistance and a PSW indicated that she would have to call the registered staff on another floor. The SDM proceeded to call 911 from his/her cellular phone as indicated to Inspector #547 that he/she was very concerned for resident #001's health.

-RN #102 arrived to the resident's floor after receiving a call that resident #001's SDM was in the home and calling for an ambulance. RN #102 had not assessed the resident yet on his shift other than information that was provided to him at the evening shift report. RN #102 indicated that the phone rang from the 911 dispatchers to confirm the home was sending resident #001 to hospital, and RN #102 confirmed and proceeded to gather documents for the resident's transfer. RN #102 indicated that not even five minutes later, the door rang and it was the ambulance that had arrived to the home and sent the resident to hospital via ambulance.

- Resident #001 was admitted to the hospital via emergency with decreased level of consciousness and required to be intubated and then transferred to the hospital's intensive care unit.

The RPN #101, RPN #103, RN #100 and RN #102 failed to re-assess resident #001's change in care requirements when the resident's status had not improved. The registered nursing staff did not revise the resident's plan of care related this significant acute episode of illness until the resident's SDM arrived in the home almost two and a half hours after the resident became unresponsive and called an ambulance himself/herself for assistance to care for the resident.

3. The licensee has failed to ensure that resident #001's plan of care was based on an assessment of the resident's needs for sleep patterns and preferences.

This is related to a complaint log # 002451-16 and CI # 2579-000021-15 reported by the home regarding resident fall with fracture. The Complainant indicated that the resident is falling while trying to get into bed, as the home is aware that he/she prefers to be in bed by a specified time in the evening.

On April 29, 2016 Inspector #547 interviewed the Director of Care (DOC) who indicated that the resident's sleep time preferences are discussed in the resident's initial care plan meeting with the family. Upon review of the resident care plan dated August 2015 prior to the resident's last fall, it was noted that no sleep pattern or preference was identified for resident #001's bed time routine. Inspector #547 and the DOC reviewed the resident's history of falls from years 2014 and 2015, and noted that every fall occurred in the resident's bedroom at the resident's bedside and that three out of four falls occurred around the specified time the family identified as the resident preferred time to be in bed.

The DOC indicated that a review of the resident's sleep preferences was discussed with the resident's substitute decision maker (SDM) after the resident's fall in October 2015 and implemented offering the resident naps in the afternoon as part of her falls prevention intervention. The resident's bed time routine and preference of no later than a specified time in the evening was never added to the resident plan of care. [s. 6. (2)]

4. The licensee has failed to ensure that resident #001's plan of care was based on an assessment of the resident's communication abilities, including hearing and language. Resident #001 is also identified in the plan of care to speak a specific language and is unable to verbally communicate in any other language with staff in the home. Resident #001 has been identified in the current plan of care as having ability to communicate to staff with non-verbal signage by pointing at objects, or pictures to express needs.

On April 28, 2016 the Assistant Director of Care (ADOC) indicated to Inspector #547 that resident #001 has difficulty with communication due to a language barrier, and that resident #001 often does things on his/her own, like transfers. The ADOC indicated that the home does not use any communication aids with the resident with front line nursing staff, however that the recreation department do activities with the resident using a picture board or tablet and they identified that resident #001 does well with pictogram. This intervention has not been implemented with front line nursing staff that she is aware of.

PSW #106 works regularly with resident #001 indicated that they do not have any communication aids to assist communication with the resident. PSW #106 indicated that she wished she could understand the resident when he/she is speaking to her, as she believes the resident has so much to say, yet nobody except the resident's family can understand.

Based on interviews, observations and record review during the course of this inspection, Inspector #547 identified that resident #001 does not have any pictogram or other communication aids in place to assist in helping his/her communicate with staff. Resident #001 was observed by Inspector #547 to speak in his/her own language with lively arm gestures and facial expressions, trying to communicate the best way he/she can. These methods have not proven effective on both occasions when the resident has required hospitalization and significant delay in transfer. The lack of understanding of the resident's concerns or signs and symptoms he/she may have been able to communicate to nursing staff at the time or before these incidents had occurred.

Additional Required Actions:

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

Issued on this 14th day of June, 2016

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA KLUKE (547)
Inspection No. / No de l'inspection :	2016_286547_0012
Log No. / Registre no:	002451-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jun 14, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE MEDEX 1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tina Nault

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. (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;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee shall ensure that residents are reassessed and their plans of care reviewed and revised when the resident's care needs change or when the care set out in the plan of care has not been effective. The home shall ensure the following is completed:

1. Documentation of change in condition assessments on every shift as required by the home's policy and procedures to include but not limited to: 24 hour shift report, resident progress notes, post-fall assessments, pain assessments, head to toe skin assessments, neurological assessments

2. Residents plan of care are reviewed, revised and updated with individualized care needs related to any change of condition

3. Review all resident care plans to include sleep patterns and preferences

4. Assess all residents in the home who have communication barriers and individualize their plan of care to ensure communication interventions are effective for all staff in the home

5. Develop a process to review, revise and analyze documentation to ensure resident interventions are followed and effective

Grounds / Motifs :

1. The licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when resident #001's care needs changed after a fall while trying to transfer into bed and sustaining a fracture.

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Resident #001 was admitted to the home on a specified date in 2012 with several complex medical diagnoses and was assessed as high risk of falls by the home on a specified date in 2013. The resident had a history of two unwitnessed falls in 2014 and once in 2015 prior to this incident in October 2015 whereby each fall occurred in the resident's bedroom at the resident's bedside. Resident #001 requires mechanical lift for transfers since admission to the home related to non-weight bearing capacity.

On this specified date in October 2015, resident #001 was found on the floor in the resident's bedroom at the resident's bedside in the evening. Resident #001's post-fall assessment for this incident indicated the resident attempted to transfer self to bed. The resident's substitute decision maker (SDM) stated upon return from the hospital “that resident #001 was tired and had pain and was trying to get into bed before the fall occurred."

Inspector #547 reviewed the resident health records and noted that the resident was assessed by the evening charge RN#100 after the resident's fall on the evening shift and then mechanically transferred into bed. RN #100 completed a post fall assessment and started a neurological flow sheet for this resident's unwitnessed fall starting at a specified time in the evening.

The DOC indicated to Inspector #547 that she noticed upon review of resident #001's fall on this specified date in October 2015 that there was no documentation of any other reassessments completed by the registered nursing staff for resident #001 from the post fall assessment completed by RN #100 at a specified time mid-evening and call placed to the resident's SDM regarding the resident's fall. The last documented assessment of this unwitnessed fall by any registered nursing staff was completed three hours after the fall occurred by the night shift (2230-0630 hours) with only a neurological assessment. The DOC

indicated that the home would expect documentation in the progress notes as well as ongoing documented assessment of the resident after any fall on every shift.

Inspector #547 interviewed RPN #111 who worked on the day shift (0630-1430 hours) on the day following resident #001's fall. RPN #111 indicated she was informed during the shift report that resident #001 had a fall during the evening shift and to monitor a specified location on the resident's lower body. PSW #106 asked RPN #111 at 0730 hours to go and assess another specified location of resident #001's lower body and not the location identified during the shift report. RPN #111 indicated that resident #001's specified location on the lower body was assessed and noted to be swollen and painful to touch as the resident stated " Oh -Oh" during palpitation of this body location. RPN #111 decided to call the home's nurse practitioner regarding the resident's condition. The home's nurse practitioner came to the home and assessed the resident and indicated to RPN #111 to send the resident to hospital for x-ray for possible fracture.

The resident was sent to hospital on this specified date fifteen hours after resident #001 fell. Resident #001 returned from hospital this same day diagnosed with fracture.

The registered nursing staff failed to re-assess resident #001 after a fall in the evening of a specified date in October 2015 extending the need to send the resident to hospital until fifteen hours later and diagnosed with fracture. (547)

2. Secondly, the licensee has failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed on a specified date in April 2016 with an acute episode of illness.

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- PSW #105 reported to RPN #101 and #103 working on the other wing of the floor that they needed to assess resident #001 as not responding suddenly after being transferred to bed.

- RPN #103 informed RPN #101 that she would go assess the resident. RPN #103 assessed the resident, indicated that resident #001 was breathing rapidly and not responding when she shook the resident's shoulder. RPN #103 then went and reported this to the Charge RN #100 and requested her to go and assess resident #001's condition.

- RN #100 and RPN #101 then went to assess resident #001 and completed the resident's vital signs and noted that the resident's oxygen saturation level was low and the resident was not responding when spoken to which RPN #101 indicated to RN #100 that "this was not like this resident". RN #100 instructed RPN #101 to continue with her assessment and she would go get an oxygen tank on another floor in the home. RN #100 returned five minutes later and no change in the resident, and provided the resident with three litres of oxygen via nasal prongs. RN #100 left and instructed RPN #101 to continue to monitor the resident. RPN #101 returned to resident #001's room less than 15 minutes later indicated the resident's responsiveness was unchanged but the oxygen saturation level had increased a bit. RN #100 returned to resident #001's room at this time approximately 45 minutes after the resident was found unresponsive and decided to increase the resident's oxygen. RPN #101 asked RN #100 if they were going to send resident #001 to the hospital. RN #100 indicated that since all of the rest of the resident's vital signs were stable and the resident did not look in distress as appeared to be in a deep sleep that the resident did not need to go to the hospital at this time. RPN #101 indicated that she preferred to call

the resident's Substitute Decision Maker (SDM) of this change in the resident's condition. RPN #101 called the resident's SDM approximately 70 minutes after the resident was found unresponsive on both home and cellular lines but was unable to reach the SDM.

-RPN #101 provided night charge RN #102 report of the first floor at approximately 2220 hours including resident #001's health condition, and that she thought resident #001 should be sent to the hospital. RN #102 indicated that he would assess the resident after he received all the floors shift reports. RPN #101 indicated to Inspector #547 that they follow the decisions of the charge RN's in the home as per the home's process.

-RN #100 provided RN #102 shift report at 2230 hours and indicated that resident #001 required monitoring as the resident was not responding as usual and required oxygen via nasal prongs for low oxygen saturation suddenly for no apparent reason. RN #100 indicated to Inspector #547 that "when she provided report to RN #102 that she realized that she should have sent resident #001 to hospital with these symptoms." RN #100 further stated that she "offered RN #102 assistance to prepare and send the resident to the hospital before she left to go home, but RN #102 indicated that he had it covered."

-RN #102 proceeded to receive the other floor shift reports. RN #102 stated to Inspector #547 " that he did not think resident #001 was in any distress and was provided oxygen based on saturation levels from the reports provided to him from RPN #101 and RN #100 on the evening shift."

- Resident #001's SDM arrived to the home at approximately almost two and a half hours after the resident became unresponsive as two attempts had been made by the home to reach the SDM that evening. The resident's SDM went to resident #001's room and noted the resident was not breathing well and not responding when spoken to. The SDM left the resident's room asking for assistance and a PSW indicated that she would have to call the registered staff on another floor. The SDM proceeded to call 911 from his/her cellular phone as indicated to Inspector #547 that he/she was very concerned for resident #001's health.

-RN #102 arrived to the resident's floor after receiving a call that resident #001's SDM was in the home and calling for an ambulance. RN #102 had not assessed the resident yet on his shift other than information that was provided to him at

the evening shift report. RN #102 indicated that the phone rang from the 911 dispatchers to confirm the home was sending resident #001 to hospital, and RN #102 confirmed and proceeded to gather documents for the resident's transfer. RN #102 indicated that not even five minutes later, the door rang and it was the ambulance that had arrived to the home and sent the resident to hospital via ambulance.

- Resident #001 was admitted to the hospital via emergency with decreased level of consciousness and required to be intubated and then transferred to the hospital's intensive care unit.

The RPN #101, RPN #103, RN #100 and RN #102 failed to re-assess resident #001's change in care requirements when the resident's status had not improved. The registered nursing staff did not revise the resident's plan of care related this significant acute episode of illness until the resident's SDM arrived in the home almost two and a half hours after the resident became unresponsive and called an ambulance himself/herself for assistance to care for the resident. (547)

3. The licensee has failed to ensure that resident #001's plan of care was based on an assessment of the resident's needs for sleep patterns and preferences.

This is related to a complaint log # 002451-16 and CI # 2579-000021-15 reported by the home regarding resident fall with fracture. The Complainant indicated that the resident is falling while trying to get into bed, as the home is aware that he/she prefers to be in bed by a specified time in the evening.

On April 29, 2016 Inspector #547 interviewed the Director of Care (DOC) who indicated that the resident's sleep time preferences are discussed in the resident's initial care plan meeting with the family. Upon review of the resident care plan dated August 2015 prior to the resident's last fall, it was noted that no sleep pattern or preference was identified for resident #001's bed time routine. Inspector #547 and the DOC reviewed the resident's history of falls from years 2014 and 2015, and noted that every fall occurred in the resident's bedroom at the resident's bedside and that three out of four falls occurred around the specified time the family identified as the resident preferred time to be in bed.

The DOC indicated that a review of the resident's sleep preferences was discussed with the resident's substitute decision maker (SDM) after the

resident's fall in October 2015 and implemented offering the resident naps in the afternoon as part of her falls prevention intervention. The resident's bed time routine and preference of no later than a specified time in the evening was never added to the resident plan of care. [s. 6. (2)]

4. The licensee has failed to ensure that resident #001's plan of care was based on an assessment of the resident's communication abilities, including hearing and language. Resident #001 is also identified in the plan of care to speak a specific language and is unable to verbally communicate in any other language with staff in the home. Resident #001 has been identified in the current plan of care as having ability to communicate to staff with non-verbal signage by pointing at objects, or pictures to express needs.

On April 28, 2016 the Assistant Director of Care (ADOC) indicated to Inspector #547 that resident #001 has difficulty with communication due to a language barrier, and that resident #001 often does things on his/her own, like transfers. The ADOC indicated that the home does not use any communication aids with the resident with front line nursing staff, however that the recreation department do activities with the resident using a picture board or tablet and they identified that resident #001 does well with pictogram. This intervention has not been implemented with front line nursing staff that she is aware of.

PSW #106 works regularly with resident #001 indicated that they do not have any communication aids to assist communication with the resident. PSW #106 indicated that she wished she could understand the resident when he/she is speaking to her, as she believes the resident has so much to say, yet nobody except the resident's family can understand.

Based on interviews, observations and record review during the course of this inspection, Inspector #547 identified that resident #001 does not have any pictogram or other communication aids in place to assist in helping his/her communicate with staff. Resident #001 was observed by Inspector #547 to speak in his/her own language with lively arm gestures and facial expressions, trying to communicate the best way he/she can. These methods have not proven effective on both occasions when the resident has required hospitalization and significant delay in transfer. The lack of understanding of the resident's concerns or signs and symptoms he/she may have been able to communicate to nursing staff at the time or before these incidents had occurred.

(547)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 12, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 14th day of June, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Kluke

Service Area Office /
Bureau régional de services : Ottawa Service Area Office