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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 23, 2018	2018_617148_0021	027408-17, 029363-17, 000045-18, 000307-18, 000392-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

AMANDA NIXON (148)

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): June 26 and 27, July 3-6, 2018

This inspection included five critical incident reports (CIR), including three logs, 027408-18, 029363-17, 000045-18. and 000307-18, related to an incident that caused injury to a resident for which the resident is taken to hospital; and one log 000392-18 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Assistant Director of Care, Clinical Care Coordinator, Office Manager, Nursing Clerk, Resident Assessment Instrument (RAI) Coder, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Worker (PSW) and residents.

In addition the Inspector reviewed resident health care records, observed the resident's care environment and reviewed documents related to the licensee's investigation into the identified critical incidents, as applicable.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

As described in WN #2, a critical incident report was submitted to the Director, describing that on a specified date, resident #001 sustained an injury during the provision of care and was sent out to hospital whereby the resident required treatment.

The plan of care in place at the time of the incident described the needs of the resident to include one person, extensive assistance for bed mobility with limited assistance for transfers.

The most recent Minimum Data Set (MDS) assessments indicated that resident #001 required two person extensive assistance for bed mobility in addition to two person, extensive assistance for transfers.

The documentation maintained by PSWs within the Point of Care electronic record, indicated that the resident was provided one to two person, extensive to total assistance with bed mobility and two person, total assist with transfers. During an interview with the RAI RPN Coder who conducted the assessments, it was reported that the resident required two person assistance for bed mobility/repositioning due to the resident physical abilities and behaviours.

At the time of the incident the plan of care for resident #001 was not based on the most recent assessment of the resident or the needs of the resident.
(Log 000045-18) [s. 6. (2)]

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 the plan of care is based on an assessment of the resident and the resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

A critical incident report (CIR) was submitted to the Director, describing that on a specified date, resident #001 sustained an injury during care and was sent out to hospital for further assessment and treatment. In an interview with PSW #105 and the Clinical Care Coordinator along with a review of the CIR, it was described that PSW #105 was providing care to resident #001 while in bed; at some point during care the resident sustained an injury during repositioning. The home's investigation into the incident indicated that the injury occurred during repositioning as it related to the application of a sling for transfer.

The home's policy titled Mechanical Lift Procedure, #LP-01-03, was provided to the Inspector, which indicated that two persons are to be present for the application of a sling. In addition to this, the resident's most recent Minimum Data Set (MDS) assessments indicated that resident #001 required two person extensive assistance for bed mobility in addition to two person, extensive assistance for transfers.

PSW #105 did not use safe positioning techniques when assisting resident #001 with care on a specified date.
(Log 000045-18) [s. 36.]

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 staff use safe positioning techniques when assisting residents, to be implemented voluntarily.

Issued on this 23rd day of July, 2018

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

Original report signed by the inspector.