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 prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2019	2018_665551_0004	015835-18, 027346-18	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

MEGAN MACPHAIL (551)

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): October 25, 26 and 31 and November 1, 2 and 5, 2018.

The following Critical Incident System (CIS) logs were inspected:
- 016289-18 / CIS # 2579_000029_18 related to allegations of staff to resident abuse.
- 027346-18 / CIS #2579_000042-18 related to the fall of a resident. The finding issued under r. 8 related to this inspection is included in report 2018_655551_0003.
- 015835-18 / CIS #2579_000032_18 related to resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, a Recreation Worker, the Social Worker, the Registered Dietitian, the Laundry Valet, the Physiotherapist, the Program Manager, the Maintenance Manager, the Assistant Director of Care, the Director of Care and the Administrator.

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

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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. Staff and others involved in the different aspects of care failed to collaborate with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complimented each other.

On a specified date, Critical Incident Report 2579-000042-18 was submitted to the Director under O. Reg 79/10, s. 107 (3) to report an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health status.

Resident #001 had resided at the home for several years. In the Resident Assessment Protocol (RAP) written for ADL Functional Rehabilitation Potential for Assessment Reference Date of a specified date, it was noted that the resident required extensive assistance for bed mobility.

On a specified date, during the provision of care, resident #001 was left unattended and rolled out of bed and onto the floor.

On a specified date, the physician (MD) assessed the resident and ordered a portable x ray of specific body parts. The MD noted that the resident appeared to have pain and ordered a specific pain medication to be administered every two (2) hours as needed.

A review of the Digital Prescriber's Orders indicated that the first and second checks of the order were completed two days after the MD wrote it at 0530 hours and 1550 hours, respectively. A note indicated that the request for the x ray was faxed on the same day as the checks were completed.

The x ray was taken the next day. Three days later at approximately 2100 hours, the results of the x ray were faxed to the home and indicated a specified injury. Resident #001 was sent to hospital. During the hospitalization, the resident developed complications and passed away.

According to the licensee's policy titled Physician/Nurse Practitioner Orders (RC-16-01-04): All physician/nurse practitioner orders will be processed within 24 hours of being written.

Staff failed to collaborate in that the physician's order for an x ray, written on a specified date, was not processed until two days later.

(log 027346-18) [s. 6. (4) (a)]

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 collaborate with each other so that their assessments are integrated, consistent with and compliment each other, 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 did not ensure that staff used safe positioning techniques when assisting resident #001.

On a specified date, Critical Incident Report (CIR) 2579-000042-18 was submitted to the Director under O. Reg 79/10, s. 107 (3) to report an incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change in the resident's health status.

In the RAP written for ADL Functional Rehabilitation Potential for Assessment Reference Date of a specified date, it was noted that the resident required extensive assistance for bed mobility.

According to the CIR, on a specified date, during the provision of care, resident #001 was left unattended and rolled out of bed and onto the floor.

In an interview with PSW #105, it was reported that on a specified date while preparing to give the resident care, the PSW turned away from the resident, and then saw the resident fall out of bed. According to RPN #103 who assessed the resident after the fall, the fall mat had been removed when the PSW initiated care.

An x ray taken on a specified date (results made available three days later) showed a specific injury.

In a discharge summary written by the physician after the resident passed away, it was noted that this was the second time that the resident had fallen from bed during care.

Safe positioning techniques were not used on a specified date when resident #001 was left unattended in bed and fell onto the floor and suffered a specific injury. (log 027346-18) [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 safe positioning techniques are used when assisting residents, to be implemented voluntarily.

Issued on this 28th day of January, 2019

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

Original report signed by the inspector.