Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jun 5, 6, 7, 2012	2012_029134_0012	Complaint

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, (DOC), two Registered Nurses (RN), the Registered Practical Nurse, to several Personal Support Workers (PSWs) and to one Substitute Decision Maker (SDM).

During the course of this inspection the inspector conducted a complaint inspection log number O-000899-12.

During the course of the inspection, the inspector(s) Reviewed two identified residents' health records and met with the two identified residents.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére dé la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to comply with section 24 (1) (2) of the LTCHA 2007, in that the licensee did not report the suspicion of abuse of a resident by another resident that resulted in harm.

The progress notes of Resident # 1 were reviewed. There is an entry made on March 4, 2012 at 6:30 indicating that the night PSW reported that he/she heard noise coming from room [redacted] that when he/she entered the room he/she observed Resident # 1 standing next to Resident # 2's bed and that Resident # 1 was yelling and swearing at Resident # 2. There is an entry made in the progress notes specifying that blood was dripping from Resident # 2's right cheek. A laceration measuring 1.1 x 0.5cm was observed by the RN on duty.

On March 8, 2012 at 22:15, there is an entry in Resident #2's progress notes indicating that a bruise was observed on the resident's upper right chest and that it might have been caused during the reported incident of March 4, 2012.

A letter of concern was sent to the Administrator on March 9th, 2012 by Resident # 2's SDM, who indicated that on the evening of March 8, 2012, while he/she was preparing Resident # 2 for bed with the assistance of the PSW, they both noticed for the first time, a large yellow bruise on Resident # 2's right shoulder and chest. The SDM indicated that he/she believed the bruise to Resident # 2's body was caused by Resident # 1, during the incident of March 4th, 2012.

The home failed to report the suspicion of abuse and the information upon which it is based to the Director, as per the legislative requirement.

Issued on this 7th day of June, 2012

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, LTCH Inspector #134