Ontario

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

Rapport d'inspection prévue la *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
September 1, 2, 7, 8, 13, 14, 15 and 16, 2011	2011_029134_0005	Log # O-000904 **Follow-up to Inspections log # 2011_134_2579_17Mar090623** **Log # O-003023**

Licensee/Titulaire
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 Baselin Rad, Ottawa, ON K2C-3K6

Name of Inspector(s)/Nom de l'inspecteur(s)
Colette Asselin # 134

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a follow-up inspection to one Compliance Order # 001 served on March 31, 2011.

During the course of the inspection, the inspector spoke with the home's Administrator, Director of Care, two Assistant Director of Care and the Registered Nurse.

During the course of the inspection, the inspector reviewed three residents' medical records, including: the electronic medication administration records, progress notes, physician's orders and vital signs records, for June, July and August 2011.

The following Inspection Protocol were used during this inspection:

- Nutrition and Hydration
- Medication
- Responsive Behaviors

No findings of Non-Compliance were found during this inspection.

See "Corrected Non-Compliance" table at the end of this report.

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	

CORRECTED NON-COMPLIANCE
Non-respects des exigences corrigés

REQUIREMENT EXIGENCE	TYPE OF ACTION/ORDER	ACTION/ ORDER #	INSPECTION REPORT #	INSPECTOR ID #
LTCHA 2007, S.O. 2007, c.8, s. 6 (1) (c), (9) (3), (10) (b) (c), (11) (a) (b).	CO	# 001	2011_134_2579_17Mar090623	#134

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature (de la représentante de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** September 22, 2011

Ontario

Ministry of Health and Long-Term Care

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Ministére de la Santé et des Soins de longue durée

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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 1, 2, 7, 8, 13, 15, 21, 22, 2011	2011_029134_0005	Follow up

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 Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), two Assistant Directors of Care (ADOC), the Environmental Manager, Registered Nurses (RN), Physicians, Personal Support Workers, Laundry Aids, Dietician and Residents.

During the course of the inspection, the inspector(s) reviewed the health records of several residents, including progress notes, physician orders, plan of care, electronic medication administration records (eMARS), the Licensee's Admission Policy related to labeling of personal items and the Licensee's process to report and locate residents' lost items.

During the course of this inspection the inspector conducted one follow-up inspection, log # O-000904-11, one critical incident inspection, log # O-000774-11 and four complaint inspections, log # O-000656-11, # O-002890-10, # O-001292-11 and # O-001465-11.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry

Dignity, Choice and Privacy

Medication

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Resident Charges

Responsive Behaviours

Sufficient Staffing

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. 52. Pain management

Specifically failed to comply with the following subsections:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with section 52 (2) of the O. Reg.79/10 in that it failed to reassess the pain of an identified resident, who had sustained an injury, using a clinical appropriate assessment instrument.

One identified resident, sustained an unwitnessed injury in the month of March, 2011. The resident was examined by the doctor and nurse practitioner the next day. An x-ray was ordered the next day of the injury and was not done until five days later.

There are several documented entries indicating the resident expressed pain for several days and was not reassessed using a clinical appropriate assessment instrument, was not offered analgesics to manage the pain or discomfort except for two occasions and there is no indication that other measures were used to promote comfort and pain relief.

An x-ray had been ordered and was not done until 5 days later.

The resident was diagnosed with a fracture.

This WN relates to critical incident log # O-000774-11

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

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Findings/Faits saillants :

1. The licensee has failed to comply with section 37 (1) of the O. Reg.79/10 in that it failed to label resident's personal items.

The licensee has an Admission Policy, "Number 04-02-02", specifying that attendant staff need to make sure that all resident's personal articles are appropriately marked, to prevent loss or confusion later (clothing, dentures, eyeglasses, hearing aids).

One identified resident, lost his/her eye glasses. The eye glasses were not labeled at the time they were lost.

The plan of care has an entry under visual perception, specifying the following: 1. that glasses are to be worn at all times, 2. ensure the glasses are clean and labelled.

The laundry room was visited. Three pairs of unidentified eye glasses were found in the laundry. These were unlabelled and consequently never returned to their owner.

There were 4 other pairs of unlabelled eye glasses observed on the third floor unit, which were not claimed by residents.

This WN relates to complaint log # O-001465-11

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 by ensuring that every resident's personal items including personal aids such as dentures, glasses and hearing aids are clearly labelled to prevent loss or confusion, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following subsections:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 33 (1) of the O.Reg. 79/10 in that two baths per week were not given to one identified resident.

One identified resident, was interviewed September 8, 2011 at 13:30. It was reported that a shower was missed due to the unit being short staffed. The sign-in sheet for the months of July was reviewed. There is an indication that the unit was short staffed by one PSW on the day shift in question.

The resident's electronic flow sheet was reviewed for the month of July 2011 and there is an entry indicating the resident did not have a shower as per plan of care and bath list, on the specified date.

The ADOC, was interviewed September 6, 2011 and indicated residents are to have 2 baths/showers per week. It was specified that all efforts are made to ensure residents receive their 2 baths/showers per week. If they miss their baths because the unit is short staffed, the bath would be reassigned the next day as per the residents' preference and time of bathing. It was specified that if one resident did not get his/her bath/shower because staffing was short one day, extra staff would be called in to ensure residents who have missed their baths/shower would have it the next day. This did not happen for the identified resident, because the shower was not provided to this resident the next day.

This WN relates to complaint log # O-001292-11

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with section 89 (1) (a) (iv) of the O.Reg. 79/10 in that it failed to follow their process to locate resident's personal items.

The home is using a form called "We Want To Hear From You".
It has several sections to be completed by the initiator - Date, Name, Phone Number, Department and the initiator of the form needs to check off one of three boxes. (Comment, compliment or concerns) to identify the focus of the issue.

This form was reviewed as it relates to a request made in January 2011 by a resident's substitute decision maker(SDM), who identified several items of clothing that were lost within six days of admission.

The items were identified.

The Follow-up section of the form, was not completed by the environmental manager to indicate what actions were taken and the results of the investigation.

The missing clothing items were not found.

This WN relates to complaint log # O-000656-11

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with section 53 (4) (a) (b) and (c) of the O. Reg. 79/10 in that it failed to take actions to respond to the needs of two residents with responsive behaviors, including assessment, reassessment and interventions and to document the residents' responses to interventions.

Between February and April, 2011, there are several documented chart entries indicating one identified resident, was "a safety risk" to his/her roommate.

In February 2011 there is a documented entry in progress notes indicating the roommate was punched by the identified resident.

There is another entry in the roommate's progress notes of February 2011, reporting that the identified resident was standing next to his/her roommate's bed yelling. The RPN documented that the RN had been informed that the roommate's safety was in question and for the RN to express concern to management related to the identified resident's behaviors.

There are several documented incidents where the roommate was transferred out of the bedroom at night because he/she was disrupting the identified resident's sleep. There are several chart entries indicating that on the occasional night shift in February, March and April, 2011, the roommate was transferred to a wheelchair and kept in the small dining room because of he/she was disturbing the identified resident. According to the progress notes, this measure was taken to prevent possible altercation with the roommate and for his/her safety.

No new approaches were considered in the revision of both residents' plan of care to promote sleep, diminish agitation and address the identified resident's aggressive behavior and risks of altercations.

This WN relates to critical incident log # O-000774-11

Issued on this 16th day of September, 2011

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

Colette Asselin, inspector #134