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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 19, 2012	2012_205129_0002	H-001207-12, H-001195-11	Critical Incident System

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 MISSISSAUGA
855 JOHN WATT BOULEVARD, MISSISSAUGA, ON, L5W-1G2

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): ~~October 29, 30 & 31~~, ~~2012~~ November, 2, 6, 7, 8 & 13, 2012 RHB

During the course of the inspection, the inspector(s) spoke with residents, Registered and unregulated nursing staff, Behavioural Support staff, staff responsible for education and orientation, the Dietitian, the acting Assistant Director of Care, the acting Director of Care, the Administrative Assistant and the Administrator.

During the course of the inspection, the inspector(s) observed residents, reviewed clinical records and reviewed home records including polices, procedures, incident investigative notes and staff training information in relation to Log #H-001207-12 and #H-001195-12.

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

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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).

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 did not ensure that the staff involved in different aspects of resident #1's care collaborated with each other 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, in relation to the following: [6(4)(b)]

Nursing and dietary staff did not collaborate with each other in the development and implementation of the plan of care related to hydration and the management of the risk for dehydration for resident #1. The nutritional portion of the plan of care indicated daily fluid requirements and that the resident required constant reminders to eat and drink; however, the care portion of the plan indicated that the resident eats and drinks independently at a slow pace and that the resident frequently refuses to eat and drink. Care directions are inconsistent and as a result interventions in the nutritional portion of the plan of care were not implemented and the resident experienced two episodes of dehydration requiring additional treatment. [s. 6. (4) (b)]

2. The licensee did not ensure that resident #1 was reassessed and the plan of care reviewed and revised, when the care set out in the plan was not effective, in relation to the following: [6(10)(c)]
a) Staff in the home did not reassess or review and revise the plan of care for resident #1 when the care set out related to the risk for dehydration was not effective and the resident required treatment of dehydration on two occasions. The plan of care included a daily fluid requirement; however, food and fluid intake records indicated the resident consumed fluids fair or poorly (less than 1500cc a day) 100% of the time over a four month period in 2012. A reassessment of the resident's poor hydration did not occur over this period of time. The resident's plan of care established in April 2012 indicated that the resident is independent with eating and drinking, eats slowly, often refuses to eat and drink, specific daily fluid requirements and requires constant encouragement to eat and drink. At the time of this inspection the plan of care had not been reviewed or revised since these interventions were established in April 2012 despite this care not being effective.
b) Staff in the home did not review and revise the plan of care when care set out for resident #1 was not effective in managing responsive behaviours. A Minimum Data Set (MDS) assessment completed in April 2012 indicated that the frequency of the resident demonstrating responsive behaviours had increased since the previous assessment completed in January 2012. The MDS assessment completed in July 2012 indicated that some of the behaviours being demonstrated by the resident had increased in frequency, some of the behaviours being demonstrated remained the

same as the previous assessment and a new responsive behaviour was now being demonstrated by the resident. Staff confirmed the care plan goals established for this resident were that the episodes of responsive behaviours would be decreased or prevented, however the plan of care was not reviewed or revised when assessments indicated the goals of care were not being met. [s. 6. (10) (c)]

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 with LTCHA 2007, s., 8, 6(4)(b) and 6(10(c), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #1's right to be protected from abuse was fully respected and promoted, in relation to the following: [3(1)2]
Clinical record documentation and the home's internal investigation indicated that the resident was physically abused. Staff confirmed and documentation indicated that the resident sustained injuries during this incident. Staff also documented that a significant change in the resident's behaviour was noted following this incident. [s. 3. (1) 2.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, in relation to the following: [8(1) (b)]
Staff did not comply with the following policies/procedures included in the organized program of hydration:
a) The home's policy [Fluid Intake] #RES-05-02-05 dated December 2002 directs that:
- Registered Staff are to assess the resident's need for fluid intake and document an individual plan on the Care Plan and the progress notes. Staff did not comply with this direction for resident #1 when there was not an individual plan developed for this resident based on an assessed need to consume 1500cc of fluid each day and staff's knowledge that the resident often refuses to eat and drink.
- If there is a potential for dehydration staff are to initiate the use of the fluid balance record. Staff did not comply with this direction for resident # 1 when it was established that this resident was at risk for dehydration.
-Staff are to consider the resident's likes and dislikes when planning types of fluids offered and document this on the Resident Care Plan. Staff did not comply with this direction when the Resident Care Plan did not identify fluid likes and dislikes for resident #1 who was identified as being at risk for dehydration and staff noted that the resident would often refuse to drink.
b) The home's policy [Intake and Output] # 05-02-06 dated December 2002 directs that:
- Monitoring of residents intake and output may be initiated based on Nursing or dietary assessments or if ordered by a physician related to fluid volume deficit. Staff did not comply with this direction when the monitoring of intake and output was not initiated for resident #1 when assessments indicated that the resident was at risk for dehydration, consumed less that the identified fluid volume 100% of the time over a four month period of time and received treatment for dehydration on two occasions 2012.
Staff did not comply with the following policy, included in the program to manage responsive behaviours:
a) The home's [Responsive Behaviour] # 09-05-01 dated September 2010 directs that:
-Each resident displaying responsive behaviours will have a resident focused care plan developed and maintained that includes triggers for the behaviour. Staff in the home did not comply with this direction when clinical documentation indicates that

triggers for behaviours were not included in the care plan for responsive behaviours being demonstrated by resident #1.
- If responsive behaviours are observed a more in depth assessment of the behaviour will be undertaken. Staff in the home did not comply with this direction when they did not complete a more in depth assessment of behaviours beyond the quarterly MDS assessments when resident #1 continued to demonstrate responsive behaviours behaviour.
- Other causes for the observed behaviour are to be investigated. Staff did not comply with this directive when they identified a new responsive behaviour during an assessment completed in April 2012 and another new responsive behaviour during an assessment completed in July 2012, however clinical record documentation does not indicate that other causes for these behaviours were investigated. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents contained an explanation of the duty under section 24 to make mandatory reports, with respect to the following: [20(2)(d)]
The homes policy [Resident Abuse and Neglect] # OPER-02-02-04 dated July 2012 does not contain an explanation of the duty under section 24 to make mandatory reports immediately to the Director. [s. 20. (2)]

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

Specifically failed to comply with the following:

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; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(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 did not ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident were identified , where possible, in relation to the following: [53(4)(a)]
Staff documented that resident #1 demonstrated regular episodes of responsive behaviours. Staff and the clinical record confirmed that there was not an attempt to identify triggers for these behaviours. [s. 53. (4) (a)]

Issued on this 19th day of December, 2012

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

Phyllis Hiltz-Bontje
(Signature on Licensee Report)