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

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

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 3, 2014	2014_196157_0009	001077-13,001203-13,000476-13	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4

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

PATRICIA POWERS (157)

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): March 19, 20, 21, 2014

The purpose of this inspection was to complete an inspection three Critical Incidents.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse(RN), Environmental Service Manager

During the course of the inspection, the inspector(s) reviewed clinical health records for identified residents, reviewed identified critical incident reports, reviewed facility incident investigation records, observed staff to resident interactions, observed the provision of resident care, reviewed facility policies related to laundry processing, labelling of personal clothing, odour control, admission procedures, air temperature control and monitoring, medication administration policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. Related to resident #02 - Critical Incident Report - Log #O-001077-13
The licensee failed to ensure that the care set out in the plan of care was provided to resident #02 as specified in the plan.

The Critical Incident Report indicated that on an identified date, resident #02 who required supervision and the assistance of two staff members was discovered unattended and at risk of injury. The Personal Support Worker(PSW)responsible for the care of the resident is reported to have left the shift due to illness at least 30 minutes before the resident was found. PSW and Registered Nurse(RN) handwritten reports indicate finding the resident distraught and cold with no apparent physical injuries.

The plan of care for resident #02 directs the following related to transfers:
- resident is total assistance
- resident requires a sit to stand lift for safe transferring
- resident requires extensive assistance of two staff

On an identified date, staff member #105 transferred resident #02 without the assistance of a second staff member as directed by the plan of care.
In an interview on March 27, 2014,this was confirmed by the DOC. [s. 6. (7)]

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 care set out in the plan of care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. Related to resident #02 - Critical Incident Report - Log #O-001077-13
The licensee failed to ensure that any actions taken with respect to a resident under a program, specifically nursing and personal support services, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The Critical Incident reported that on an identified date, resident #02 who required supervision and the assistance of two staff members was discovered unattended and at risk of injury. The Personal Support Worker(PSW)responsible for the care of the resident is reported to have left the shift due to illness at least 30 minutes before the resident was found. PSW and Registered Nurse(RN) handwritten reports indicate finding the resident distraught and cold with no apparent physical injuries.

There is no evidence of any documentation related to this incident in the clinical health record for resident #02 and no evidence of any assessments of the resident's physical or emotional well being completed following the incident. Progress notes provide data the following day related to the Director of Care follow up with the resident and the resident's Power Of Attorney. [s. 30. (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 any actions taken with respect to a resident under a required program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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:

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

Findings/Faits saillants :

1. Related to resident #02 - Critical Incident Report - Log #O-001077-13
The licensee failed to immediately report to the Director when there were reasonable grounds to suspect neglect of resident #02 that resulted in harm or risk of harm to the resident.
As per O.Reg..79/10, s.5. "Neglect" is defined as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

The Critical Incident reported that on an identified date, resident #02 who required supervision and the assistance of two staff members was discovered unattended and at risk of injury. The Personal Support Worker(PSW)responsible for the care of the resident is reported to have left the shift due to illness at least 30 minutes before the resident was found. PSW and Registered Nurse(RN) handwritten reports indicate finding the resident distraught and cold with no apparent physical injuries.

Critical Incident Report was submitted the day following the incident.
There is no evidence that the Director was immediately notified of the suspected neglect of a resident that resulted in harm or risk of harm to the resident. [s. 24. (1)]

Issued on this 3rd day of April, 2014

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