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

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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
Aug 20, 2013	2013_140158_0019	S-000120-13, S-000307-13	Complaint

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 YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 8 and 9, 2013

During the course of the inspection, the inspector(s) spoke with the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed various home policies and reviewed resident health care records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management

Personal Support Services

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 O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The Inspector observed that resident # 01 was asleep in bed at 19:15hr on August 8, 2013.
Staff # S-101 stated to the Inspector on August 8, 2013 that resident # 01, who is unable to make decisions, gets tired at times and needs to go to bed early.
It was identified in the 2011 assessment, that resident # 01 likes to go to bed at 21:00hr. A current assessment regarding resident # 01 bed time routines was not found. The resident's plan of care is reflective of the 21:00hr bedtime. The home did not ensure that resident # 01 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

2. The Inspector observed that resident # 02 was asleep in bed at 19:15hr on August 8, 2013.
Staff # S-100 stated to the Inspector on August 8, 2013 that resident # 02 is unable to make decisions and is assisted to bed early. Staff # S-100 identified that the resident becomes increasingly agitated when the resident gets tired.
Staff # S-102 identified that the resident's preference is to go to bed around 21:00hr, however, this assessment was completed in 2012. A current assessment regarding resident # 02 bed time routines was not found. Resident # 02 plan of care is reflective of the 21:00hr bedtime. The home did not ensure that resident # 02 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

3. The Inspector observed that resident # 03 was in bed, in pyjamas and ready for sleep at 19:15hr on August 8, 2013. Resident # 03 who is able to make some decisions, stated to the Inspector on August 8, 2013, that the staff come and get them ready for bed even though it is too early to sleep.
There is no mention of resident # 03 bedtime routine or preference in the 14-day admission assessment or in the interdisciplinary resident care conference held recently. There is no reference to bedtime routines in resident # 03 plan of care. The home did not ensure that resident # 03 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

4. The Inspector observed that resident # 04 was sleeping in bed at 19:20hr on August 8, 2013. Staff # 101 stated that resident # 04 behaviours increase when resident # 04 becomes tired so the resident is one of the first residents who the staff prepare for bedtime.
The 2011 assessment by staff # S-103 identifies that resident # 04 prefers to go to

bed between 20:00-21:00hr. Resident # 04 plan of care is reflective of this 2011 assessment. A current assessment regarding resident # 04 sleep patterns or preference was not found. The home did not ensure that resident # 04 plan of care was based on an interdisciplinary assessment of the resident's current sleep patterns and preferences. [s. 26. (3) 21.]

5. The Inspector observed resident # 05 asleep in bed at 19:20hr on August 8, 2013. Staff # S- 105 stated to the Inspector on August 8, 2013, that resident # 05, who has moderate impairment with decision making, wants to go to bed early. An assessment completed in 2011 by staff # S-106 identified that resident # 05 goes to bed at 20:00hr. Resident # 05 plan of care is reflective of this. A current assessment regarding resident # 05 sleep patterns or preference was not found. The home did not ensure that resident # 05 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

6. The Inspector observed resident # 07 asleep in bed at 19:30hr on August 8, 2013. An assessment of resident # 07's bedtime routine or preference was not found and was not identified in the 14-day admission assessment. Resident # 07 sleep routines, patterns or preferences were not documented on their plan of care. The home did not ensure that resident # 07 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

7. The Inspector observed resident # 08 asleep in bed at 19:30hr on August 8, 2013. Staff # S-100 stated to the Inspector on August 8, 2013, that resident # 08 has been going to bed early. Staff # S-104 reviewed resident # 08 plan of care and it identified that the resident goes to bed after 21:00hr which continues to be reflected in resident # 08 plan of care. An annual assessment was completed recently and it did not make reference to resident # 08 bedtime routines. The home did not ensure that resident # 08 plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences. [s. 26. (3) 21.]

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Issued on this 21st day of August, 2013

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