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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 25, 2015	2015_396103_0018	O-001321-14, O-001450-14	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 PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

DARLENE MURPHY (103)

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): March 18, 19, 23-25, 2015

Log #O-001321-14 and O-001450-14 were included in this inspection.

During the course of the inspection, the inspector(s) spoke with Activity staff, a Personal Support worker, a Registered Practical Nurse, a Registered Nurse, the Assistant Director of Care and the Administrator.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 112 whereby a prohibited device was utilized to restrain a resident.

An anonymous complaint was received by the Ministry of Health and Long Term Care (MOHLTC) advising a resident had been tied to a wheelchair with a bed sheet by a staff member. Upon inspection, the Administrator was able to identify the resident to this inspector and stated the home was aware of the incident and had taken disciplinary action.

Resident #1's health care record was reviewed including the care plan which indicated the resident was high risk for falls and there were interventions in place to minimize this risk.

S#102 was interviewed and stated she observed Resident #1 tied with a bed sheet to the wheelchair in the common area beside the nursing desk after dinner on an identified date. The resident was observed to be leaning in a way that the sheet was holding the resident from falling forward and the resident appeared to be asleep.

S#102 stated a discussion was held with RPN S#101 who indicated they did not have time to appropriately monitor the resident. S#102 reported the incident to the RN in charge of the building at the time of the incident and to the Director of Care the following day.

RPN S#101 was interviewed and denied any involvement in the application of the bedsheet or that they had any awareness of the bed sheet when it was in place. The home did investigate the incident and disciplinary actions were taken against S#101. [s. 112.]

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 all direct care staff follow the home's policy for physical restraints, to be implemented voluntarily.

WN #2: 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. The licensee has failed to comply with LTCHA, 2007, s. 24 whereby an incident that constituted improper or incompetent treatment or care of a resident was not immediately reported to the Director.

An anonymous complaint was received by the MOHLTC stating a resident had been tied to a wheelchair with a bed sheet by a staff member on an identified date. S#102 was interviewed and stated the incident was reported to the RN in charge of the building at the time of the incident and the Director of Care was notified the following day.

The Assistant Director of Care and the home's Nurse Consultant was interviewed and agreed the incident did constitute improper care of a resident that resulted in harm or risk of harm to the resident. To date of this inspection, the incident had not been reported to the Director.

At the time of this incident, the home had already been issued a Compliance Order in regards to the failure to immediately report incidents under the LTCHA, 2007, s. 24. This order had a compliance date of December 31, 2014. As a result, this will be issued as a written notification. [s. 24. (1)]

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Issued on this 25th day of March, 2015

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

Original report signed by the inspector.