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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Nov 4, 2016	2016_178624_0030	013465-16	Resident Quality Inspection

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

BAIYE OROCK (624), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 3, 4, 5, 6, and 7, 2016

The following logs were inspected:
008462-16 and 028838-16 (alleged staff to resident neglect),
015150-16 (fall of a resident leading to hospitalization), and
015783-16 (resident to resident physical altercation).

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), the Maintenance Supervisor, the Program Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a representative of the Family Council, the President of Resident Council, as well as residents.
A tour of the home was carried out, resident health records were reviewed, an observation of medication administration and staff to resident and resident to resident interaction were also carried out during the course of the inspection. A review was also completed of the Long Term Care Home's internal investigations and relevant policies and procedures related to abuse, falls and responsive behaviors.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee failed to ensure that the plan of care for resident #030, related to toileting, sets out clear direction to staff and others who provide direct care to the resident.

Related to log #028838-16,

Resident #030 was admitted to the Long Term Care Home on a specified date with specified diagnoses. A review of resident #030's health records had an instruction on how the resident was to be assisted during the provision of care related to toileting.

On a specified date, PSW #123 reported to RN #122 and other registered nursing staff that PSW #123 had discovered resident #030 was left on the toilet for close to two hours.

In an interview conducted by Inspector #624 with PSW #120 and #121, RPN #112, and Charge Nurse RN #122, about their understanding of the instruction on how the resident was to be assisted, all four staff members provided different explanations regarding the instruction on how the resident was to be assisted.

In an interview with the DOC by Inspector #624 on a specified date, regarding what the instructions in the resident's health records meant, she provided a similar explanation as RPN #112.

The plan of care for resident #030 therefore did not provide clear directions to staff regarding the provision of assistance to the resident.

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 the plan of care of resident #030 related to toileting, provides clear directions to staff and others who provide direct care to the resident., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system in every area accessible by residents.

During the tour of the Long Term Care Home on a specified date, it was identified by Inspector #601 that the home did not have a resident-staff communication and response system in four home areas that residents had access to on the first and second floors of the home.

During an interview on a specified date, the Administrator indicated to Inspector #601 that residents currently have access to the four identified areas. During the same interview, the Administrator indicated that these four areas were not equipped with a resident-staff communication and response system.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

The licensee failed to inform the Director within three business days of an incident that led to hospitalization and change in condition of resident #025.

Related to log #015150-16,

Resident #025 was admitted into the Long Term Care Home on a specified date. On admission, the resident was noted to be ambulating and transferring independently. On an identified day, resident was found on the floor, transferred to hospital and returned with a change in her condition. The Director was not notified of this incident that led to a change in the resident's condition, until five business days after the resident was sent to hospital.

During an interview with Inspector #624 on an identified date, the DOC indicated that the incident should have been reported to the Director within three business days as legislated.

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.