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 sions de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2016	2016_282543_0010	007212-16	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

TIFFANY BOUCHER (543)

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 21 and 23, 2016

This inspection is related to a critical incident the home submitted regarding an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Registered Dietitian, Food Service Manager, Food Service Supervisor and the Restorative Care Aide (RCA).

The inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, and observed meal services.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 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. (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. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A critical incident report (CI) was submitted to the Director, whereby resident #001's primary PSW #105 stated that the resident did not appear well. Resident #001 was being assisted with their meal in the dining room by PSW #108 when they began to cough. PSW #108 stated that they stopped feeding the resident at that time and removed all food items and left the resident to settle. RCA #109 arrived on the unit and noticed that they did not appear well, at which point they brought the resident to the RPN for assessment. This resident passed away.

The Inspector reviewed this resident's most recent plan of care which identified that resident #001 had a medical condition and interventions in place which indicated that staff would report any signs and symptoms or complications related to their condition.

In an interview with PSW #105, they stated that when they provided morning care to resident #001, they noted that the resident was weak. PSW #105 also stated that they noted some gurgling, and did not provide them with mouth care.

In an interview with PSW #108, they stated that they assisted resident #001 with a meal when the resident started to cough. This PSW stated that it was normal for this resident to cough, but not normally during the meal service. The PSW then gave the resident a drink, and the resident coughed again. They stated that resident #001 continued to cough so they stopped feeding the resident. PSW #108 stated that 15 minutes after the meal service the RCA #109 arrived in the dining room when the RCA noted resident #001 was not well.

In an interview with RCA #109, they stated that they went to get resident #001 and noted that the resident was not well and had not responded to them.

In an interview with RPN #101, they stated that after the meal service RCA #109 brought resident #001 to them and stated that the resident did not look well. RPN #101 confirmed that the resident was not well and that their vital signs were unstable. This RPN revealed that PSW #105 reported after the resident had passed away, that resident #001 had not appeared well that morning when they provided them with care. They also confirmed that PSW #108 did not report any abnormalities to them prior to the meal service.

In an interview with RN #106, they stated that they assisted with the meal service in the dining room that resident #001 was in, but then went to another dining room to assist with the meal service. They stated that on their way back to the unit, a staff member asked them if they had heard about resident #001, but by the time they got to the resident's

room they had already passed away. RN #106 stated they rely on the PSWs for monitoring purposes in the dining room. They confirmed that they had not noted any changes in resident #001 while they were in the dining room, and that they had not really looked for anything because no report of any changes in resident #001's condition had been brought to their attention.

The Inspector reviewed the home's internal investigation. Documentation of staff interviews identified that resident #001's change in condition was not immediately reported to a registered staff member. The resident's primary PSW #105 confirmed that the resident was not well. PSW #108, who fed the resident their meal, confirmed that the resident was coughing throughout the meal. It was not until the RCA #109 came to get resident #001 after the meal, that they reported to the RPN #101 that they noted the resident was not well.

The Inspector spoke with the Director of Care (DOC) who stated that they had serious concerns related to the incident. They indicated that they became aware after the incident had occurred, that PSW #105 knew the resident was not themselves that particular day, but had not reported it to registered staff. The DOC stated that it is the expectation that PSWs report any changes in residents' condition to the registered staff immediately. They also confirmed that it was not until the RCA #109 arrived in the dining room, that resident #001's change in condition was reported to the RPN.

In summary, resident #001's plan of care indicated that staff would report any signs and symptoms or complications related to their medical condition. The events leading up to the incident related to resident #001 and the home's internal investigation, identified that two separate PSWs provided care to this resident without notifying registered staff members of the resident's change in condition. [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 residents' care is provided as specified in their plan of care, to be implemented voluntarily.

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Issued on this 19th day of May, 2016

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

Original report signed by the inspector.