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
Oct 18, 2013	2013_184124_0023	O-000901-13	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 KINGSTON
309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 15, 16, 17, 18, 2013.

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

During the course of the inspection, the inspector(s) completed initial tour of the home, observed staff-resident interactions, made general observations regarding resident care, reviewed resident health records and the home's "Care Planning" policy and procedure.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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.) 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. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.24. (1) in that a 24-hour admission care plan was not communicated to direct care staff within 24 hours of the residents' admission to the home.

The Director of Care (DOC) reported to the inspector that the 24 Hour Care Planning Assessment found in Point Click Care is the twenty-four hour care plan used by the home. The DOC reported that the registered staff are expected to complete this assessment within the first twenty-four hours after admission, that the Care Planning Assessment is printed and placed in the binder with the Personal Support Worker (PSW) flow sheets.

Resident #1 was a resident with diagnoses of a neurological disorder, dementia and osteoporosis who required maximal assistance with all Activities of Daily Living (ADL).

Resident #1 was admitted to the home on a specific date and four days after admission, Resident #1 sustained a fall, was sent to hospital and died shortly thereafter.

The DOC reported to the inspector that Resident #1's 24 Hour Care Planning Assessment was incomplete and had not been communicated to staff as a copy was not placed in the PSW binder. Resident #1's 24 Hour Care Planning Assessment had documented that the resident was at high risk for falls.

Resident #2 was admitted with diagnoses of arthritis, dementia, macular degeneration and osteoporosis.

The 24 Hour Care Planning Assessment for Resident #2 was completed within twenty -four hours and was not communicated to staff as it was not printed and placed in the binder with the PSW flow sheets until thirty-six days later.

Resident #2's care plan identified that the resident was at risk of falls and interventions were identified.

Resident #3 was admitted with diagnoses of arthritis, osteoporosis, and a previous fracture. Resident #3 received analgesic for left arm pain and medication at bedtime.

On the day after admission, the Morse Fall Assessment was completed and

documented that the resident was at high risk of falls and that the resident would not attempt to get up alone and walk or transfer.

The progress note dated two days after admission reported that Resident #3 was found walking in the hall in the early morning, confused and incontinent.

Seven days after admission, it is documented that in the early morning, Resident #3 was up walking without assistance wearing only socks.

The 24 Hour Care Planning Assessment for Resident #3 had not been initiated seven days after admission and therefore had not been communicated to staff. [s. 24. (1)]

2. The licensee failed to comply with O.Reg. 79/10, s. 24. (2) 1 in that the 24 hour care plan did not include interventions to mitigate the risk of falling for Resident #2.

On October 16, 2013, the Director of Care (DOC) reported that the 24 Hour Care Planning Assessment found in Point Click Care is the twenty-four hour care plan used by the home. The DOC reported that the registered staff is expected to complete this assessment within the first twenty-four hours after admission, that the Care Planning Assessment is printed and placed in the binder with the Personal Support Worker (PSW) flow sheets.

Resident #2 was admitted with diagnoses of arthritis, dementia, macular degeneration and osteoporosis. The Morse Fall Scale, completed at time of admission, indicated that Resident #2 was at high risk for falls and the impact on care planning was that the resident needed a fall mat in place while in bed.

The 24 Hour Care Planning Assessment for Resident #2 was completed within twenty -four hours and was not communicated to staff as it was not printed and placed in the binder with the PSW flow sheets until thirty-six days after admission. Under the "Falls" tab of Resident #2's 24h Care Planning Assessment it was documented that there were no potential problems related to falls and that the resident had not fallen in the past 30 or 31-180 days. No interventions related to falls were documented on the 24 Hour Care Planning Assessment.

Resident #2's 24 Hour Care Plan Assessment did not include interventions to address the resident's risk of falling. [s. 24. (2) 1.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 1st day of November, 2013

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

JMcPaland for L. Hamilton

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2013_184124_0023
Log No. / Registre no:	O-000901-13
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Oct 18, 2013
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE KINGSTON 309 QUEEN MARY ROAD, KINGSTON, ON, K7M-6P4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tawnia Pilgrim

To EXTENDICARE CENTRAL ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Order / Ordre :

The licensee shall ensure that for each resident admitted to the home, a 24 hour admission care plan is developed and communicated to direct care staff within 24 hours of the resident's admission.

Grounds / Motifs :

1. The licensee failed to comply with O. Reg. 79/10, s.24. (1) in that a 24-hour admission care plan was not communicated to direct care staff within 24 hours of the residents' admission to the home.

The Director of Care (DOC) reported to the inspector that the 24 Hour Care Planning Assessment found in Point Click Care is the twenty-four hour care plan used by the home. The DOC reported that the registered staff are expected to complete this assessment within the first twenty-four hours after admission, that the Care Planning Assessment is printed and placed in the binder with the Personal Support Worker (PSW) flow sheets.

Resident #1 was a resident with diagnoses of a neurological disorder, dementia and osteoporosis who required maximal assistance with all Activities of Daily Living (ADL).

Resident #1 was admitted to the home on a specific date and four days after admission, Resident #1 sustained a fall, was sent to hospital and died shortly thereafter.

The DOC reported to the inspector that Resident #1's 24 Hour Care Planning

Assessment was incomplete and had not been communicated to staff as a copy was not placed in the PSW binder. Resident #1's 24 Hour Care Planning Assessment had documented that the resident was at high risk for falls.

Resident #2 was admitted with diagnoses of arthritis, dementia, macular degeneration and osteoporosis.

The 24 Hour Care Planning Assessment for Resident #2 was completed within twenty-four hours and was not communicated to staff as it was not printed and placed in the binder with the PSW flow sheets until thirty-six days later.

Resident #2's care plan identified that the resident was at risk of falls and interventions were identified.

Resident #3 was admitted with diagnoses of arthritis, osteoporosis, and a previous fracture. Resident #3 received analgesic for left arm pain and medication at bedtime.

On the day after admission, the Morse Fall Assessment was completed and documented that the resident was at high risk of falls and that the resident would not attempt to get up alone and walk or transfer.

The progress note dated two days after admission reported that Resident #3 was found walking in the hall in the early morning, confused and incontinent.

Seven days after admission, it is documented that in the early morning, Resident #3 was up walking without assistance wearing only socks.

The 24 Hour Care Planning Assessment for Resident #3 had not been initiated seven days after admission and therefore had not been communicated to staff.
[s. 24. (1)]
(124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 18, 2013

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 18th day of October, 2013

Signature of Inspector / Signature de l'inspecteur : JMcPartland for L. Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

Service Area Office / Bureau régional de services : Ottawa Service Area Office