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
Jul 21, 2015	2015_288549_0017	O-000367-14, O-000368-14, O-002145-15, O-002160-15	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

RENA BOWEN (549)

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): June 29, 30 and July 2 and 3, 2015

During the course of the inspection, the inspector(s) spoke with Residents, several Personal Support Works(PSW), several Registered Practical Nurses (RPN), several Registered Nurses(RN), the Social Worker and the Director of Care.
The Inspector also reviewed Resident Health Care Records including the Plan of Care, the home`s Mechanical Lift policy, Fall Prevention and Management Program policy, Abuse policy and the home`s investigation documentation.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and implemented in accordance with all applicable requirements under the Act, and is complied with.
O. Reg. 79/10 30(1)(1) requires the home to ensure that there is a written description of the Fall Prevention and Management Program that includes its goals and objectives and relevant policies, procedures and protocols and provide for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The home's Fall Prevention and Management Program (policy reference # RESI-10-02-01) version April 2013 was reviewed and states on page 2 bullet 8 that "when a resident falls, complete a post fall assessment and update the care plan. Communicate changes in care plan to all staff." Page 3 of the policy states: :"Fall refers to any unintentional change in position where the resident ends up on the floor, ground or other lower level (CIHI Manual, 2012, p.194)."

A Critical Incident was reviewed and indicated that on a specific date in April 2014 Resident #1 became weak and was lowered to the floor by 2 PSWs. The PSWs notified RN #103 that they had lowered the resident to the floor.

On a specific date in April 2014 when providing am care to Resident #1 the PSW noted that the resident was in pain when a specific body area was manipulated and that the specific body area was also swollen. Resident #1 was sent to the hospital for further assessment of the specific body area. Upon return from the hospital, it was noted that the resident had a non-displaced fracture.

The DOC indicated to Inspector #549 that post fall assessments for residents are completed on the resident's electronic health care record.

A review of Resident #1's electronic health care record for the period in April 2014 was completed by Inspector #549. The inspector was unable to locate a completed post fall assessment for Resident #1.

On June 29, 2015 during an interview the DOC indicated that Resident # 1's weakness and being lowered to the floor is considered a fall by the home. The DOC also indicated that the expectation is that a post fall assessment would have been completed for

Resident #1.

On July 2, 2015 during an interview RN #103 indicated to Inspector #549 that on a specific date in April 2014, Resident #1 was lowered to the floor by two PSWs which RN #103 did not consider a fall and therefore did not complete a post fall assessment. RN #103 indicated that she is unaware of the home's fall definition as defined in the home's Fall Prevention and Management Program policy # RESI-10-02-01.

The DOC confirmed with Inspector #549 on July 2, 2015 that the home's Fall Prevention and Management Program policy was not complied with. (Log# O-00367-14) [s. 8. (1) (a),s. 8. (1) (b)]

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 home's Fall Prevention and Management Program policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring techniques when transferring residents.

A Critical Incident Report submitted by the home was reviewed and indicated that on a specific date in May, 2015 Resident #3 sustained a laceration from falling out of a sling during a mechanical lift transfer from a wheelchair to a bed. The resident was transferred on a specific date in May 2015 to hospital for further assessment.

Resident #3 was assessed on a specific date in April, 2015 (using the Resident Transfer/Lift Assessment tool on Point Click Care) to be a mechanical lift using a medium

sized (yellow border) sling for all transfers. The Plan of Care states under transfer focus that the Resident is to use size medium sling (yellow border) for all transfers.

During an interview on June 30, 2015 PSW #100 indicated to Inspector #549 that she was asked by RPN #101 to transfer Resident #3 from the wheelchair to the bed.

PSW #100 indicated that she was aware that the resident was a mechanical lift. PSW #100 indicated there was a sling in the resident's room which she used for the transfer.

PSW #100 indicated to Inspector #549 that she thought the sling might have been too big for the resident but it was in the room so it must be the right one and proceeded to use it for the transfer.

PSW #100 indicated that she did not verify if the sling size she was using was the size the resident was assessed for. RPN #101 assisted PSW #100 with the transfer and indicated during an interview with Inspector #549 on June 30, 2015 that she did not verify the sling size before transferring the resident.

PSW #100 indicated that when she lifted Resident #3 up from the wheelchair using the mechanical lift, RPN #101 removed the wheelchair from underneath the resident and this was when Resident #3 fell out of the sling hitting sustaining a laceration.

RPN # 101 indicated that after Resident #3 fell out of the lift she checked the size of the sling used for the transfer and found it to be a size large. RPN #101 also indicated that the Resident #3 was assessed and required a medium sling for all transfers.

During an interview with the DOC it was confirmed with Inspector #549 that Resident #3 had been assessed for a medium size sling and upon completing the home's internal investigation the sling used to transfer Resident #3 on the specific date in May, 2015 was a large size sling.

PSW #100 and RPN 101 indicated that they have received re-training in safe transferring techniques when transferring residents using a mechanical lift including verifying the appropriate size sling for each individual resident.

The DOC confirmed with Inspector #549 that the staff involved have received re-training related to safe transferring techniques including verifying the appropriate size slings for each individual resident. The DOC also indicated that the home now has colour coded

dots on the lift logos to match the sling size to be used for residents who require a mechanical lift.(Log# O-002160-15) [s. 36.]

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 be implemented voluntarily.

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) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident’s health condition and for which the resident is taken to a hospital.

A Critical Incident indicated that Resident #2 had a fall on a specific date in April, 2015. Resident #2 was transferred to hospital and returned the same day from hospital with a noted head injury. Monitoring the resident frequently when in room was initiated. Resident#2 is to be in a tilt chair at all times unless nursing staff present.The Licensee informed the Director through the Critical Incident Reporting System 3 business days after the Licensee became aware of the significant change in the resident's health status for which the resident was taken to a hospital. (Log# O-000368-14) [s. 107. (3)]

2. The licensee has failed to ensure that a report in writing to the Director of any incident that causes an injury to a resident for which the resident is taken to hospital and that results in a significant change the resident’s health condition is made within 10 days of becoming aware of the incident.

The Director was notified of an incident that caused an injury to Resident #3 for which the resident was taken to hospital and which resulted in a significant change in the resident’s health condition on a specific date in April, 2015 through an e-mail to the Centralized Intake, Assessment and Triage Team. Resident #3 fell out of the sling during a mechanical lift transfer and sustained a laceration. The Licensee made a written report to the Director through the Critical Incident Reporting System on specific date in May, 2015 which is 14 days after the Licensee became aware of the incident. (Log# O-002160-15) [s. 107. (4) 1.]

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 Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to hospital and that the report in writing is made to the Director with 10 days of becoming aware of the incident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Report to the Director was made within 10 days of becoming aware of the alleged incident of staff to resident abuse.

The Director was notified of an incident of alleged staff to resident abuse on a specific date in April, 2015 through an e-mail sent to the Centralized Intake, Assessment and Triage Team. The Licensee made an initial written report to the Director using the Critical Incident Reporting System on a specific date in May, 2015 which is 12 days after the Licensee became aware of the incident. (Log #O-002145-15) [s. 104. (2)]

Issued on this 21st day of July, 2015

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

Original report signed by the inspector.