Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 27, 2019	2019_730593_0037	020149-19, 020719-19, 022406-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

GILLIAN CHAMBERLIN (593), MEGAN MACPHAIL (551)

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): December 2 - 6, 9 - 10, 2019.

Critical Incident log #020149-19 (2579-000040-19) was inspected, related to a fall causing an injury to a resident, for which the resident was taken to hospital and which resulted in a change of condition.
Critical Incident log # 020719-19 (2579-000044-19) was inspected, related to an unplanned evacuation.
Critical Incident log #022406-19 (2579-000045-19) was inspected, related to an alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), the Assistant Director of Care (ADOC), the Physiotherapist, Maintenance staff, Registered Nursing staff, Personal Support Workers (PSWs) including the behavioural support PSW and residents.

The Inspector observed the provision of care and services to residents, staff to resident interactions, residents' environment and reviewed resident health care records and licensee audit records.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Responsive Behaviours
Safe and Secure Home

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	Légende 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 resident #002 as specified in the plan.

i) According to a review of the resident's health care record, resident #002 had a history of falls. The record review indicated that a bed alarm was implemented and then removed 13 days later. Resident #002 was hospitalized for a seven day period and the bed alarm was reapplied on day two of the hospital admission, to be resumed upon their return from hospital.

Two weeks after their return from hospital, resident #002 fell and sustained multiple injuries. In an interview with RN #113 who assessed the resident after they had fallen, the resident had gotten out of bed and walked around the bed and towards the sink before falling. According to the RN, the bed alarm was not on at the time of the fall.

ii) Following resident #002's fall and subsequent injuries, a fall mat on the right side of the resident's bed was implemented. During the inspection at approximately 1100 hours, resident #002 was observed to be sleeping in their bed. A fall mat was not present on the floor. In an interview with RN #115, they indicated that the resident required a fall mat beside the bed when they were in the bed.

Care was not provided to resident #002 as specified in the plan when the bed alarm was not active when the resident fell, and during the inspection when the resident was sleeping in bed without a fall mat on the floor. [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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 27th day of December, 2019

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

Original report signed by the inspector.