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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Mar 11, 2016	2016_200148_0007	005514-16	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 STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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

AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), GILLIAN CHAMBERLIN (593), JOANNE HENRIE (550)

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): February 29- March 4 and March 7-10, 2016, on site.

The following inspection logs were also completed during the time at the home: O-001891-15, 002016-16, 031403-15 and 030653-15 related resident transfers or falls resulting in injury and hospital admission; O-001917-15 related to resident to resident abuse; O-002475-15 related to involvement of resident's substitute decision maker regarding changes to plan of care.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Resident Program Manager, Registered Dietitian, Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Nursing Clerk, Food Service Workers, Residents and Family Members.

In addition, the inspection team reviewed resident health care records, relevant policies and procedures including those related to the home's complaint process, staffing patterns and annual evaluation, Resident and Family Council meeting minutes and the home's planned menu and activity calender. Inspectors also conducted a tour of residential and non residential areas including door security and observed resident and staff interaction, meal services, medication administration and resident care.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

8 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).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care. 2007, c. 8, s. 6 (5).

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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to residents #019, #035 and #036.

Female residents #035 and #036, were observed between the dates of March 1 and 4, 2016 to have long facial hairs on both chin and upper lip. Resident's #035 and #036, were unable to express their preferences for facial hair grooming, due to cognitive impairment.

The daily flow sheets for January and February 2016, indicate that resident #036 was

provided shaving care on three specified dates. The plan of care for personal hygiene indicates that the resident requires assistance, with no direction specifically related to facial hair care.

The daily flow sheets for January and February 2016, indicate that resident #035 was provided shaving care on seven specified dates.The plan of care for personal hygiene indicates that the resident requires assistance, with no direction specifically related to facial hair care.

Inspector #148 spoke with PSWs #103, #104 and #108, as it relates to the facial hair care of residents #035 and #036. Two PSW’s indicated that the shaving care for both residents would be provided when the resident was scheduled for a bath. However, PSW #103, also indicated that she would usually provide the resident with shaving care during regular morning care, as needed. As it relates to the care for both resident #035 and #036, PSW #104, who is the primary care giver at the time of the Inspectors observations, indicated that she would provide shaving as needed when she saw that the facial hair was long. PSW staff interviewed indicated that the facial hair for both residents should be removed, however, were not clear as to the frequency that shaving care would be required to assist resident #035 and #036 to remain free from facial hair.

Female resident #019 was observed with long facial hairs above the lip and on chin during the inspection, from February 29, 2016 to March 7, 2016.

During an interview with Inspector #593, on March 4, 2016, PSW #111 reported that resident #019 was usually shaved once per week. They added that this would be completed on one of the resident's bath days, however PSW #111 did not work the last bath day so the shave was not completed. PSW #111 further reported that one of the other PSWs should be completing this when PSW #111 is not working. PSW #111 further reported that when this task is completed, it is documented on the PSW Daily Care Flow Sheets.

During an interview with Inspector #593, on March 3, 2016, resident #019 reported that her facial hair is groomed whenever she goes to the salon, which is approximately once every three weeks. The resident reported that whenever she feels like the hairs need to be shaved, she will go to the home’s salon for this to be completed.

During an interview with Inspector #593, on March 7, 2016, the home’s Hairdresser #112 reported that she does not complete any grooming of facial hair for this resident, nor

have they ever done this.

A review of resident #019’s current care plan, found no documented interventions related to grooming of facial hair for this resident.

A review of the PSW Daily Care Flow Sheets for resident #019 for the period January 1, 2016 to February 29, 2016, found that there was no documentation indicating that shaving or removal of facial hair had been completed.

During an interview with Inspector #593, on March 7, 2016, the DOC reported that they were not sure whether grooming of female resident facial hair would be included in the care plan. It should be part of the regular hygiene and grooming that is completed for each resident if required, however, it may have to be more specific in the care plans for this task to be completed. The DOC later reported that she spoke with resident #019’s regular PSW #111 and PSW #111 who reported that they have tried to shave this resident, however the resident has expressed that they prefer the hairs to be plucked, which the DOC reported they will not do, and the resident advised the PSW that they will attend the salon for this to be done.

The plan of care for residents, #019, #035 and #036, do not provide clear direction to staff related to personal hygiene as it relates to the care of facial hair.
(148 and 593) [s. 6. (1) (c)]

2. The licensee has failed to ensure that the plan of care was based on an assessment of resident #043's needs and preferences.

A review of the health care record indicates that on two specified dates, resident #043 was left unattended on the toilet with a tab alarm applied. In both instances, the resident left the toilet and fell; the most recent fall resulting in a laceration and fracture.

The most recent Minimum Data Set (MDS) Assessment, describes the most recent fall and denotes that the staff are to remain in the bathroom with resident for toileting with the goals and interventions to be added to the care plan. The current plan of care for fall risk, indicates that due to a history of seizures, staff are to attach a tab alarm while on the toilet. The current plan of care for toileting, directs staff to not leave the resident unattended due to the resident's seizure condition.

Inspector #148 spoke with the primary care giver, PSW #105 and regular day PSW #106, who both indicated that due to the resident's fall risk, the resident was not to be left unattended on the toilet. With regards to the use of a tab alarm, PSW #105 noted the alarm is used on the resident's wheelchair and while in bed. She reported that given the resident can not be left unattended while toileting, the tab alarm is not needed.

The plan of care related to the fall risk of Resident #043, is not based on the most recent assessment or the resident's needs as it relates to the use of a tab alarm.
(Log 0020216-16) [s. 6. (2)]

3. The licensee has failed to ensure that the resident, the residents substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

On a specified date, resident #047’s daughter went to the home to take the resident out for a leave of absence. When she was handed the resident's medication packs she noticed there was one pill missing and questioned RN #S116 who was the nurse on duty at the time. The nurse explained to her that the missing medication was a blood pressure pill, which had been discontinued by the resident’s physician 10 days prior and the power of attorney (POA) had been informed of this change.

Inspector #550 reviewed the resident’s health records and confirmed the discontinuation of the blood pressure medication with additional directions for another medication in the same note. A progress note on the dame date indicated that RN #S116 had left a message for the POA regarding the changes in medication but no other details.

During an interview, RN #S116 indicated to the Inspector that the message she left to the POA was possibly regarding the changes for the other medication, not the blood pressure pill, she did not document the message that was left and she does not recall exactly what was said.

The resident’s POA indicated to the Inspector that the message left by the nurse, was regarding the changes for the other medication because it’s a medication that is not covered and the home needed her authorization that the family would accept to pay for this other medication. She indicated there was no mention of the blood pressure medication being discontinued and that she would never have agreed to have this medication discontinued as the resident had been taking this medication since prior to

the admission to the home.

Resident #047’s substitute decision maker was not given the opportunity to participate fully in the development and implementation of the resident’s plan of care regarding the resident’s blood pressure medication. [s. 6. (5)]

4. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #043 as specified in the plan.
(Log 002016-16)

On a specified date, resident #043 was toileted by PSWs #109 and #110, the resident was left unattended on the toilet with a tab alarm applied. The resident removed the alarm and walked to the hallway where the resident fell and sustained lacerations and fracture.

The plan of care for toileting at the time of the fall, indicates that the resident required supervision when in the washroom and for staff to not leave the resident unattended.

Inspector #148 spoke with the home's DOC regarding this incident, who indicated that both PSW staff members involved did not provide the care to resident #043 as specified in the plan of care, resulting in an injury to the resident. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in resident #046’s plan of care is documented.
(Log O-001891-15)

On a specified date, during the evening shift, resident #046 sustained a skin tear on the lower leg during a two person transfer.

Inspector #573 reviewed resident #046’s plan of care that was in effect at the time of the incident, which indicates that the resident requires extensive physical assistance with two staff for transfers and toileting.

A progress note, on the date of the transfer, indicated that the resident's lower leg was hit by the bed rail when PSWs were transferring the resident from the wheelchair to the bed.

During a review of the PSW documentation in the daily flow sheet for resident #046, Inspector #573 found no documentation for the date of the transfer, on evening shift for

toileting and transfers indicating that resident #046 was transferred with extensive assistance with two person's physical assistance.

Inspector #573 spoke with DOC who indicated that the home conducted an internal investigation and follow up with the registered nursing staff and PSW staff members who were involved in the incident. When inspector requested the home's internal investigation documents, the DOC was unable to provide the home's internal investigation report or any supporting investigation documents related to the incident.

On March 9, 2016, Inspector #573 and DOC reviewed resident #046's PSW documentation in the daily flow sheet. The DOC agreed with the inspector that there was no PSW staff documentation on the date of the incident, evening shift for toileting and transfers indicating that resident #046 was transferred with extensive assistance with two person's physical assistance. Further the DOC indicated to Inspector #573 that the expectation of the PSW staff is to document in the flow sheets when care is provided to the residents. [s. 6. (9) 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: (1) the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident, as it relates to the management of grooming, specifically facial hair and (2) the care set out in the plan of are is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 were 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, is completed with.

In accordance with section 21 of the Act, the licensee of a shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

During an interview, resident #002 indicated to Inspector #550 that a complaint had been made to the Administrator that $40.00 was missing, which occurred sometime in early 2016 and that it was never found.

The Administrator indicated to Inspector #550 that on February 7, 2016, resident #002 verbally reported to her that sometime between 0800 hours on February 6th to 0900 hours Sunday February 7th, that the money had gone missing. The Administrator indicated to the Inspector she did not follow the home's policy on complaints as she did not consider this incident to be a complaint but rather a concern.

After reviewing the incident, the Inspector determined the incident to be a verbal complaint and reviewed the home's policy on complaints titled "Complaints", policy #09-04-06.
Page 2 of 9, #1. h. indicated:
At the end of the investigation, the person conducting the investigation, the Department Manager and the Administrator will meet to review the findings and complete a written response to the author of the complaint.

The Administrator indicated to the inspector that at the end of her investigation, she did not complete a written response to resident #002; the author of the complaint.

As such, the home's policy related to complaints was not complied with. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are kept closed and locked.

During the initial tour of the home, February 29, 2016, Inspector #593 observed that the door to the center court stairway on level one was unlocked. Inside the stairwell was a locked door leading to the stairway going down and a locked door leading to an outside secure area. The stairway leading up to the second floor was open and accessible from the stairwell.

During an interview with Inspector #593, March 8, 2016, the Administrator reported that all the doors leading to stairwells of the home are kept locked and require a code or key for access. When it was reported to the Administrator that the door to the center court stairway on level one was unlocked, the Administrator responded that, yes, this is sometimes unlocked as they have a resident who walks in the outdoor secure area year round. The Administrator added that the door is kept unlocked so the resident does not have to wait in the stairwell, when they are finished and want to come back onto the unit.

The licensee has failed to ensure that doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

During the initial tour of the home, February 29, 2016, Inspector #593 observed that the door to the housekeeping storage room level two B Hall South was unlocked. Housekeeping staff #114 was observed at the other end of B Hall in a resident room with the housekeeping cart.

During an interview with Inspector #593, February 29, 2016, Housekeeping staff #114 reported that the doors to the housekeeping storage room are to be kept locked and when advised that the door was unlocked, was observed to lock this door immediately.

During an interview with Inspector #593, March 8, 2016, the Administrator reported that doors to housekeeping storage areas are to be kept closed and locked. When it was reported to the Administrator that the door was found unlocked, the Administrator indicated that this was unacceptable and was surprised that this was unlocked as believed these doors locked automatically when closed. Observations of the door at this time, confirmed that this door did not lock automatically. [s. 9. (1)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

Resident #36 was observed to be seated in a wheelchair. The resident spends most of the day seated in the wheelchair and it is the resident’s primary mode of locomotion. The resident’s wheelchair was observed on March 1, 2, 3 and 4, 2016, at various times of the day. On each observation the wheelchair was noted to be heavily soiled by a thick white crusted matter on the right arm rest and circumference of the right wheel. Similar debris, in lesser amounts, was also observed on the left arm rest and circumference of the left wheel. Over the course of these same observations, Inspector #148 noted that the resident, at times, will have a production of oral phlegm which the resident will remove with a tissue or by spitting to the right side when a tissue is not readily available.

Inspector #148 confirmed that the home has a schedule in place for the weekly cleaning of resident equipment. The wheelchair of resident #36 is scheduled for weekly cleaning on the Thursday night shift. On March 3, 2016, the cleaning schedule was modified for unrelated reasons and resident #36’s wheelchair did not get cleaned.

On March 4, 2016, in the company of the home’s DOC, the wheelchair was observed in the same state as described above. The DOC indicated she was unaware of this issue and agreed that the wheelchair was in need of cleaning. She suspected that the resident’s chair would require more than weekly cleaning to maintain it in a clean and sanitary state.

Resident #36’s equipment, specifically the wheelchair, was not kept clean and sanitary.
[s. 15. (2) (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on, at a minimum, interdisciplinary assessment of sleep patterns and preferences with respect to resident #027.

Resident #027 was admitted in August 2015 and requires extensive to total assistance for activities of daily living including transfer from wheelchair to bed, by use of mechanical lift.

Inspector #148 spoke with a family member of resident #027, who is a frequent visitor to the home. The family member indicated that resident #027's customary routine, prior to admittance into the home, was to go to bed at approximately 2100 hours. The family member noted that due to the staff schedule the resident is put to bed at 1800-1830 hours or 1930 hours, based on the staffs scheduled supper breaks. Although, the family member understood that the staff required their break, she felt that that bedtime was too early for resident #027.

The Inspector spoke with the primary care giver for the evening shift, PSW #115, who reported that the roommate of resident #027, prefers to be put to bed between 1800-1830 hours, prior to the staff member leaving for her supper break. At this time, PSW #115 will offer to put resident #027 to bed, if the resident says yes than she will transfer the resident to bed at this time. If resident #027 says no to being put to bed at that time, the resident will be put to bed at approximately 1930 hours, after her return from supper break and when a second staff member is available to assist with the transfer. When the resident has an evening bath, the bedtime may be pushed to 1930-2000 hours. The most recent MDS assessment of February 2016, indicates that the resident is severely impaired and can never/rarely makes decisions regarding tasks of daily life.

A review of the plan of care indicates no item related to the sleep patterns and preferences for resident #027. An assessment on admission, whereby sleep was assessed, indicates rest periods for the day shift and time of rise in the morning. The assessment did not include the resident's pattern or preferences of bedtime at night. When asked, PSW #115 indicated that there was no written reference or plan of care for this resident's sleep patterns and preferences rather it is something that is known by the staff who regularly work with the resident. [s. 26. (3) 21.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 56. Residents’ Council

Specifically failed to comply with the following:

s. 56. (2) Only residents of the long-term care home may be a member of the Residents' Council. 2007, c. 8, s. 56 (2)

Findings/Faits saillants :

1. The licensee has failed to ensure that only residents of the home are members of the Residents’ Council.

During an interview with Inspector #593, on March 4, 2016, the President of the Residents’ Council #016, reported that family members regularly attend the monthly Resident Council meetings. Resident #016 was not sure why they are attending their meetings and also had concerns as sometimes family members are attending the meetings, even when their resident is not attending.

A review of the resident council minutes for the past three months, found family members documented under attendees, for each of the Resident Council meetings during this time period.

During an interview with Inspector #593, on March 4, 2016, the Resident Program Manager, who is the liaison for the council, confirmed that there are four family members who do regularly attend the Resident Council meetings. [s. 56. (2)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 64. A licensee of a long-term care home shall attend a meeting of the Residents’ Council or the Family Council only if invited, and shall ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of either Council only if invited. 2007, c. 8, s. 64.

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff, including the Administrator, and other persons involved in the management or operation of the home attend a meeting of the Residents' Council only if invited.

During an interview with Inspector #593, on March 4, 2016, the President of the Residents' Council #016, reported that an agenda is provided to them prior to the Residents' Council meetings and this will include which of the management are attending the meetings and what they are discussing. Resident #016 added that they are not attending by invite from the Council, they are attending because they want to present something to the Council. Resident #016 further reported that they had a Residents' Council meeting this morning and there were four managers of the home in attendance. He added that their report took 45 – 50 minutes of the hour allocated and as a result the resident council members had to skip items that were planned on the agenda.

A review of the resident council minutes for the past three months, found management reports documented at each of the three meetings held during this time period. During the December 2015 Resident Council meeting, four managers attended to present their report; during the January 2016 Resident Council meeting, five managers attended to present their report and during the February 2016 Resident Council meeting, six managers attended to present their report.

During an interview with Inspector #593, on March 4, 2016, the Resident Program Manager, who is the liaison for the council, confirmed that management from the home do attend every Resident Council meeting. The Resident Program Manager added that usually every January, they put it to the Council with a vote about management attending every meeting of the year to discuss their section and this is considered a blanket approval for the year ahead. She reported however, that this has not been done since January 2015. [s. 64.]

WN #8: 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 :

1. The licensee has failed to ensure that the Director was not informed within three business days after the occurrence of an incident that caused an injury, for which the resident was taken to hospital resulting in a significant change in resident's health condition.
(Log 030653 -15)

On a specified date, resident #049 had a fall and transfer to hospital. Two days later, the hospital called the home to inform that resident #049 was diagnosed with a fracture and needed to wear a shoulder immobilizer for six weeks.

On March 09, 2016, Inspector #573 spoke with Director of Care who indicated that resident #049's fall, resulted in significant change in the resident's health status.

The Critical Incident Report for resident #049 was submitted by the home nine days after being informed of the significant change. [s. 107. (3.1) (b)]

Issued on this 24th day of March, 2016

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

Original report signed by the inspector.