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 soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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
Nov 16, 2016	2016_417178_0016	003992-15, 004748-15, 010054-15, 014322-15, 028444-16	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 STARWOOD
114 STARWOOD ROAD NEPEAN ON K2G 3N5

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

SUSAN LUI (178)

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): October 5, 6, 11, 12, 13, 14, 17, 18, 19, 2016.

The following Critical Incident intakes were inspected:
003992-15, 004748-15, 010054-15, and 014322-15, regarding resident falls resulting in injury.
028444-16, regarding a resident to resident altercation resulting in injury to a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Associate Director of Care (ADOC), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), residents.

During the course of the inspection, the inspector also reviewed resident records, including progress notes, assessment records, plans of care and consult notes, reviewed home records including policies and training records, observed residents, their environments and resident care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **3 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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. This non-compliance is related to Critical Incident Intake #028444-16.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #005 has dementia and exhibits responsive behaviours. An identified Critical Incident Report (CIR) was submitted by the home, reporting that on an identified date, resident #005 engaged in an altercation with a co-resident, causing injury to the co-resident.

Review of resident #005's care plan and kardex in the section binder, revealed that two copies of the resident's care plan and kardex were present in the binder. The two copies differed with regards to the resident's responsive behaviours and interventions developed to address the behaviours.

The older kardex stated that the resident is socially abusive and resists care. The more

recent kardex stated that the resident is verbally abusive, physically abusive, and socially abusive.

The two care plans differed in that the most recently revised care plan states that the resident is verbally, physically aggressive, resistive to care and socially inappropriate. This care plan also included two identified interventions for responsive behaviours which did not appear on the older version of the care plan. The older version of the care plan present in the binder did not include these behaviours or interventions for resident #005.

During interviews with PSW staff #105 on October 13, 2016, and with the home's ADOC on October 14, 2016, both informed the inspector that the PSWs access the care plan and kardex located in the section binder in order to determine the care each resident requires. On October 13, 2016, PSW #105 indicated the older unrevised kardex when she showed the inspector what she would use when she needs to refer to a written plan of care for resident #005. This unrevised kardex did not include the fact that the resident was verbally and physically abusive.

During an interview with the home's DOC on October 13, 2016, she indicated that the older versions of resident #005's kardex and care plan should have been removed when the updated versions were placed in the section binder. [s. 6. (1) (c)]

2. This non-compliance is related to Critical Incident Intake #028444-16.

The licensee has failed to ensure that staff and others who provide direct care to the resident were kept aware of the contents of the plan of care.

Review of resident #005's progress notes confirm that on an identified date, resident #005 was witnessed engaging in an altercation with resident #006, causing resident #006 to sustain an identified injury.

Review of the current plan of care for resident #005 confirmed that the resident is verbally, physically aggressive, resistive to care and socially inappropriate.

Interviews with PSW staff #105 on October 13, 2016 revealed that she works full time days, and has provided primary care for resident #005 for approximately three weeks. On October 13, 2016, PSW #105 stated that she is unaware of the resident ever being physically aggressive towards staff or other residents. [s. 6. (8)]

3. This non-compliance is related to Critical Incident Intake #028444-16.

The licensee has failed to ensure that the plan of care for resident #005 was reviewed and revised at any other time when the resident's care needs changed.

Review of RAI MDS assessment on an identified date, revealed that resident #005 had exhibited physical and verbal aggression, and that the resident's Aggressive Behaviour Scale (ABS) score had risen by two points out of six. The resident was described as having periodic verbal and physical aggression, which was noted to be new as per that review.

Review of resident #005's plan of care confirmed that no change was made in the resident's plan of care as a result of the assessed changes in the resident's behaviour. The plan of care was not updated to include the fact that the resident was verbally and physically aggressive until approximately six weeks later, when it was revised by registered staff #107. During an interview with registered staff #107 on October 14, 2016, she stated that she revised resident #005's plan of care on an identified date, because the resident was due for a quarterly review.

During an interview with the home's ADOC on October 14, 2016, he confirmed that in September 2016, resident #005 had physical altercations with two other residents on the unit, injuring both of the other residents.

During an interview with registered nursing staff #111 on October 14, 2016, she confirmed that when resident #005 was assessed as exhibiting periodic verbal and physical aggression in August 2016, the resident's care plan was not revised to include physical and verbal aggression as behaviours.

During an interview with the ADOC on October 14, 2016, he indicated that resident #005's plan of care should have been revised to include the fact that the resident was exhibiting verbal and physical aggression when the resident was first assessed to be exhibiting these behaviours in August 2016. [s. 6. (10) (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 plan of care sets out clear directions to staff and others who provide direct care to the resident
- staff and others who provide direct care to the resident are kept aware of the contents of the plan of care
-the plan of care is reviewed and revised at any time when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. This non-compliance is related to Critical Incident Intake #028444-16.

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm had occurred, did immediately report the suspicion and the information upon which it was based to the Director under the LTCHA.

Resident #005 has dementia and exhibits responsive behaviours.

Review of resident #005's progress notes, and interviews with the home's DOC and ADOC on October 14 and 17, 2016, identified the following incidents:
-On an identified date, resident #005 engaged in an altercation with resident #006, which resulted in an injury to resident #006.
-On an identified date, resident #005 was witnessed in a physical altercation with resident #007, resulting in bruising to resident #007.

During an interview with the home's ADOC on October 14, 2016, he indicated that the first above noted incident of resident to resident abuse was not reported to the Director under the LTCHA.

During an interview with the home's DOC on October 17, 2016, she indicated that the second above noted incident of resident to resident abuse was not reported to the Director under the LTCHA. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. This non-compliance is related to Critical Incident Intake #028444-16.

The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

Resident #005 has dementia and exhibits responsive behaviours. An identified Critical Incident Report was submitted by the home, reporting that on an identified date, resident #005 engaged in an altercation with a co-resident, causing injury to the co-resident.

Review of the identified Critical Incident Report revealed that on an identified date, resident #005 engaged in an altercation with resident #004 which resulted in injury to resident #004, requiring resident #004's transfer to hospital for assessment and treatment.

Interview with the home's ADOC on October 14, 2016, confirmed the above description of the incident between residents #004 and #005.

On October 14, 2016, the inspector reviewed resident #005's medical record, including progress notes and incident reports. No documentation was found of the above mentioned incident in which resident #005 engaged in an altercation with resident #004, resulting in injury to resident #004.

Interviews with the home's DOC and ADOC on October 14, 2016, confirmed that the incident was not documented in resident #005's record as a result of an oversight, but that monitoring and other interventions were initiated for resident #005 as soon as it became known that the resident had engaged in an altercation with a co-resident, and those interventions were documented. [s. 30. (2)]

Issued on this 17th day of November, 2016

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

Original report signed by the inspector.