Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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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
Jan 16, 2017	2017_593573_0001	034993-16	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

ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161)

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): January 04, 05, 06, 09, 10, 11, 12 and 13, 2017.

Complaints and Critical Incidents Inspections were completed as part of this Resident Quality Inspection:
Complaint Logs# 030839-16, 031023-16 and 032322-16 related to resident care and services.
Critical incident Logs# 010411-16, 030567-16 and Log #000328-17 related to falls that cause an injury to a resident and resulted in a significant change in condition.
Logs# 030755-16 and 034805-16 related to resident to resident alleged physical abuse.
Log# 000697-17 related to staff to resident alleged verbal abuse were inspected.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, the Presidents of Resident and Family Councils', Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Support Services Supervisor, Resident Program Manager, Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s) toured residential and non-residential areas of the home, observed a medication pass including medication room, observed recreation activities, observed exercise therapy classes, observed resident and staff interactions. In addition, the inspectors reviewed the home's relevant policies, reviewed minutes for Residents' Council and reviewed Resident Health Care records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
2 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident’s plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident’s physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the use of a Personal Assistance Service Device (PASD) under subsection (3) to assist a resident with a routine activity of daily living included in a resident's plan of care only if, the use of the PASD has been consented to by the resident or, if the resident is incapable, a Substitute Decision-Maker (SDM) of the resident with authority to give that consent.

In accordance with LTCHA 2007, s. 33 and O. Reg 79/10, s.111, a PASD is a device used to assist a person with a routine activity of living that limits/ inhibits freedom of movement and which the resident is unable to physically or cognitively remove. The licensee shall ensure that for those residents using devices as PASDs, under section 33 of the Act, the use of the PASD is reasonable and that consent has been obtained and

documented from the resident or by the resident's substitute decision maker.

On January 06, 2017, Inspector #573 observed resident #005 and resident #006 lying in their beds with two half bed rails in the upright position on both sides of the bed frame. The two half bed rails were placed in the middle of the residents bed frame.

Inspector #573 reviewed resident #005's current written plan of care which identified that the resident required the use of two bed rails for repositioning and bed mobility. Further resident #005's plan of care identified that the resident was at high risk for falls due to self-transfer. Inspector reviewed resident #006's current written plan of care which identified that the resident required the use of two bed rails for repositioning and bed mobility. Further resident #005's plan of care identified that the resident was at high risk for falls and directed the staff to use safety bed alarm when resident #006's is in bed.

On January 06, 2017, Inspector #573 spoke with PSW #106, who indicated that two bed rails were used for resident #005's and resident #006's bed mobility and for the safety of the residents. Furthermore, PSW #106 indicated that resident #005 was at high risk of falls since resident would self-transfer from bed to wheelchair.

On January 06, 2017, during an interview with Inspector #573, RN #102 indicated that the two half bed rails were used to assist with resident #005 and resident #006's repositioning and bed mobility. The RN #102 indicated to the inspector that the two bed rails were used as a PASD. Further, RN #102 indicated that both the residents were physically unable to release the bed rails on their own.

Inspector #573 reviewed resident #005 and resident #006's health care records with RN #102 and there were no consents that had been obtained and documented regarding the use of two half bed rails as PASD either from the resident or from the resident's SDM. [S. 33. (4) 4.]

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 ensue the use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to ensure that a response in writing is provided within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On January 06, 2017, during an interview, the President of Resident's Council indicated to the Inspector #573 that the Council does not always receive a written response within 10 days from the licensee regarding any concern or recommendation made by the Council.

On January 06, 2017, Inspector #573 reviewed the minutes of the Residents’ Council meeting from June 2016 to December 2016. The following concerns and recommendations were identified by the Council.
October 2016 minutes – concerns regarding clutter (equipment) in the unit hallways.
November 2016 minutes – concerns regarding the presence of house flies in the main dining room during meal hours.
December 2016 minutes – recommendations regarding specific main entries/ meals on the menu.

The Resident Program Manager, who was assigned to assist the Residents’ Council, indicated to the Inspector #573 that any concerns or recommendations from the Residents’ Council are documented and sent to the appropriate department managers. The Resident Program Manager indicated that the concerned department manager will provide a written response to the Council.

On January 09, 2017, Inspector #573 reviewed the above identified Residents’ Council concerns and recommendations in the presence of the Resident Program Manager. Upon review, there is no written evidence to support that a written response from the licensee regarding the above identified concerns was communicated within 10 days to the Residents' Council. [S. 57. (2)]

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 concerns and recommendations from the Residents' Council are responded to in writing within 10 days, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every Licensee of a long term care home who receives a written complaint concerning the care of a resident or the operation of the long term care home shall immediately forward it to the Director, LTCHA.

On January 10, 2017, Inspector #573 spoke with resident #025's SDM who indicated that she/he wrote a written complaint (e-mail) on a specified date, to the Director of Care (DOC) concerning nursing care provided to the resident in the home. A review of resident #025's SDM e- mail to the home indicated that on a specified date and time, resident #025 was provided a bath by PSW #110, which brought stress, fear and discomfort to the resident. Further the SDM's email identified concerns related to lack of resident's privacy, when staff were providing personal care to a resident in a shared bedroom.

On January 11, 2017, during an interview, the DOC indicated to the Inspector #573 that she received an email from the resident #025's SDM concerning the care of resident #025 on a specified date. The DOC indicated that she immediately investigated the resident #025's SDM concerns and the investigations were ongoing. Further the DOC indicated to the inspector that the written complaint was not forwarded to the Director under the LTCHA, as required.(Log# 030839-16) [s. 22. (1)]

Issued on this 16th day of January, 2017

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

Original report signed by the inspector.