Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 16, 19, 20, 22, Oct 28, Nov 24, Dec 9, 2011	2011_050151_0008	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE NORTHWESTERN ONTARIO INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE TIMMINS
15 Hollinger Lane, Box 817, Schumacher, ON, P0N-1G0

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

MONIQUE BERGER (151)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with
- Administrator
- Director of Care
- Registered Staff
- Personal Care Workers
- Resident

During the course of the inspection, the inspector(s)
- reviewed the home's program relating to Responsive Behaviors,
- reviewed policies relating to Responsive Behaviors,
- reviewed resident's health care record,
- reviewed resident's plan of care
- review of resident's latest RAI/MDS assessments in consideration of change in health care status,
- reviewed education records for the last year,
- conducted home walk-through on a daily basis,
- observed staff to resident interactions,
- observed care and service delivery to residents.

The following Inspection Protocols were used during this inspection:

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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 subsections:

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).

Findings/Faits saillants :

1. A resident of the home had an incident of responsive behavior. The physician's note by the hospital's Emergency Physician sent to the home indicated that family had provided a suggestion for consideration in the plan of care when the resident would return to the home. In addition, the physician's note identified the trigger to the responsive behavior.

Inspector 151 reviewed the resident's plan of care and could find no reference in regards to the intervention identified by the family member.

Together with the Inspector, two staff persons reviewed the resident's health care record and subsequent plan of care. Both staff persons confirmed that the information was not there and should have been.

The designate of the resident/SDM has not been given an opportunity to participate fully in the development and implementation of the plan of care.
[LTCA,2007 S.O.2007,c.8, s. 6. (5)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following subsections:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

Findings/Faits saillants :

1. A resident of the home had an incident of responsive behavior.

Inspector 151 reviewed the resident's health care record and could find no documentation supporting that, post responsive behavior demonstrated by this resident, the resident was consistently being monitored and assessed for recurrence of the symptoms and that these assessments were being communicated as per the home's established protocols.

In an interview with the Inspector, a staff person stated that the resident had specific symptoms as precursor to the responsive behavior identified. Inspector could find no record that this information was communicated nor was this information found in the resident's current plan of care.

In summary, the needs of the resident with responsive behaviors were not met by the home's monitoring and internal reporting protocols. [O.Reg.79/10, s. 53. (1) 3.]
2. ***** A resident of the home had an incident of responsive behavior. The physician's note by the hospital's Emergency Physician sent to the home indicated that family had provided a suggestion for consideration in the plan of care when the resident would return to the home. In addition, the physician's note identified the trigger to the responsive behavior.

Inspector 151 reviewed the resident's plan of care and found that it does not include the family's direction. In addition, the plan of care makes no reference to the physician's assessment as to the trigger for the behavior.

together with the Inspector, two staff persons reviewed the resident's health care record and subsequent plan of care. Both staff persons confirmed that the information was not there and should have been.

The written strategies do not include techniques and interventions to prevent, minimize or respond to the responsive behaviors.
O.Reg.79/10, s. 53. (1) 2.]

Issued on this 12th day of December, 2011

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

M. Berger - Inspector 151