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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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 28, 2016	2016_264609_0027	029009-16	Complaint

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 YORK
333 YORK STREET SUDBURY ON P3E 5J3

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

CHAD CAMPS (609)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 11-13, 2016.

This inspection was conducted as a result of a complaint submitted to the Director related to the home's treatment of resident #001 and their family.

A follow up inspection #2016_264609_0026 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Physician, Support Services Manager, Food Services Supervisor, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family of residents.

The inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed licensee policies, procedures, programs, and relevant health care records.

Ad-hoc notes were used during this inspection.

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

- **2 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident’s right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference was fully respected and promoted.

A complaint was submitted to the Director in September 2016 which alleged that on a specified day the home’s staff interfered with an outside agency's reassessment of resident #001.

A review of the complaint outlined that an appointment to reassess resident #001 took place in the home with the resident’s Substitute Decision-Maker (SDM), family, members of the home’s staff and an identified physician. During the course of the appointment, the home's staff left after the SDM and family requested it. Within minutes and without being invited, two members of the home's management team entered the appointment and insisted on staying.

The complaint further outlined that the two members of the home's management team were asked to leave several times before one of resident #001’s family members escorted the two members of the management team out of the appointment.

During an interview with resident #001’s SDM on a specified day, they indicated that they wanted the meeting with the identified physician to be private to provide the most objective reassessment possible of resident #001. They further indicated that the SDM and family had to insist several times that the two members of the home's management team leave until a family member escorted them out of the room.

During an interview with one member of the home's management team on a specified day, they indicated that because the home had made a referral to the identified physician to reassess resident #001, staff of the home should have been present during the appointment. The home's management team member verified that after members of the home’s staff were asked to leave, they and one of the other home's management team members entered the appointment and insisted in participating. After several requests to leave, a member of resident #001’s family escorted them out of the room.

During an interview with the identified physician on a specified day, they verified that the home as well as resident #001’s family, both made referrals for reassessment on the same day. They indicated that the two members of the home's management team entered the appointment uninvited after the family had requested members of the home's other staff to leave and further verified that family escorted the two members of the

management team out of the room after several requests to leave.

During an interview with the Administrator on a specified day, they stated yes when asked if it was the expectation of the home that a resident's right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference was fully respected and promoted. The Administrator stated no when asked if resident #001's right to consult in private was fully respected on a specified day. [s. 3. (1) 14.]

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 every resident's right consult in private with any person without interference is fully respected and promoted, to be implemented voluntarily.

WN #2: 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. (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. The licensee has failed to ensure that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care.

A complaint was submitted to the Director on a specified day, which alleged that resident #001’s plan of care was changed without the participation of the resident’s SDM.

During an interview with the SDM for resident #001 on a specified day, they explained how they were concerned about the health status of resident #001 and had requested a copy of the resident’s plan of care from the home. The SDM stated that they found that on a specified day, the home added a particular set instructions to staff related to the care of resident #001. The SDM further explained that they were not involved in the decision to add these instructions to the plan of care, nor did they provide consent.

A review of the plan of care for resident #001 verified that on a specified day, a particular set of instructions were added to the resident's plan of care.

A review of the progress notes for resident #001 found no mention that the SDM was involved in changes to the resident’s plan of care.

A review of the home's policy titled "Care Planning- 03-01-02" date of origin September 2010 indicated that when the care plan was updated, the resident and family/SDM were to be involved with and informed of the changes.

During an interview with the ADOC on a specified day, they verified that a particular set of instructions were added to resident #001's plan of care without involving the resident's SDM in the decision.

During an interview with the Administrator on a specified day, they stated yes when asked if it was the expectation of the home that the resident, the resident’s substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident’s plan of care. The Administrator stated no when asked if this occurred when a particular set of instructions were added to resident #001’s plan of care on a specified day. [s. 6. (5)]

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 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, to be implemented voluntarily.

Issued on this 1st day of December, 2016

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

Original report signed by the inspector.