Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the
Long-Term Care Homes Act, 2007, S.O. 2007, c.8

	☐ Licensee Copy/Copie du Titulaire	☒ Public Copy/Copie Public	
Name of Inspector:	Kelly-Jean Schienbein	**Inspector ID #**	158
Log #:			
Inspection Report #:	2011_056158_0002		
Type of Inspection:	Critical Care		
Date of Inspection:	May 30, 31, June 1, 2, 3, 2011		
Licensee:	EXTENDICARE NORTHWESTERN ONTARIO INC 333 York Street, SUDBURY, ON, P3E-4S4		
LTC Home:	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3		
Name of Administrator:	Sandra Moroso		

To EXTENDICARE NORTHWESTERN ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to:
LTCHA, 2007 S.O. 2007, c.8, 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).

Order:
The licensee shall ensure that the falls prevention strategies outlined in a resident's plan of care are provided to the resident as specified in the plan.

Grounds:
1. The resident was observed by the inspector at 15:50 h on May 31, 2011, to be sitting in a wheel chair in the dining room with no staff present. The resident's wheel chair was observed by the inspector to be in a straight back position and not in a tilted position as specified in the plan of care.

This order must be complied with by:	July 12, 2011

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(b)

Pursuant to: LTCHA, 2007 S.O. 2007, c.8, 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).
Order: The licensee shall prepare, submit and implement a plan for achieving compliance ensuring that the plan of care of all residents at high risk of falls is reviewed and ensuring strategies identified in the resident 's plan of care are implemented and reviewed so that care is provided as planned. The plan for achieving compliance shall be submitted by July 15/11 to: Kelly-Jean Schienbein, Nursing Inspector fax # 705 564-3133
Grounds: 1. The resident was observed by the inspector at 15:50 h on May 31, 2011, to be sitting in the wheel chair in the dining room with no staff present. The resident's wheel chair was observed by the inspector to be in a straight back position and not in a tilted position as specified in the plan of care. 2.. The resident's plan of care identified the use of floor mats as an intervention in falls prevention. The inspector did not observe a floor mat to be in place when the resident was in bed. The registered staff on the floor where the resident resides verified that floor mats are no longer used in the home. (158)

This order must be complied with by:	August 12, 2011

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this(these) Order(s) in accordance with section 163 of the *Long-Term Care Homes Act, 2007.*

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for service for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:.

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007.* The HSARB is an independent group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

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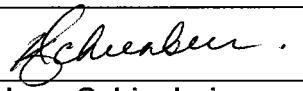
Direction de l'amélioration de la performance et de la conformité

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 21 day of July , 2011.	
Signature of Inspector:	
Name of Inspector:	Kelly-Jean Schienbein
Service Area Office:	Sudbury

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

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Health System Accountability and Performance Division
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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
May 30, 31, Jun 1, 4, Jul 5, 6, 7, Sep 20, 21, 2011	2011_056158_0002	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 YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

KELLY-JEAN SCHIENBEIN (158)

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 the Director of Care, Activity Manager, Environmental Manager, Assistant Director of Care from Extendicare Falconbridge, Registered staff (RN,RPN), Personal Support Workers (PSW), housekeeping staff, dietary staff and residents

During the course of the inspection, the inspector(s) conducted a walk throughout all resident home areas and some common areas, observed resident care, observed staff practices and interactions with the resident, reviewed the health care record of resident [redacted]

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. (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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. A resident was observed by the inspector at 15:50h on May 31/11, to be rocking back and forth while seated in the wheel chair in the dining room with no staff present. The wheel chair was observed by the inspector to be in a straight back position. The resident's plan of care which was reviewed by the inspector on May 31/11 identified that when the resident is sitting in the wheel chair and the wheel chair is in a straight back position, monitoring every 15 minutes is to be done. During the 25 minute time period between 15:50h to 16:15h, there was no staff observed by the inspector in the dining room after 15:50h, although the resident remained in the dining room. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in the plan.[s.6(7)]
2. The resident was observed by the inspector at 15:50h on May 31/11, to be rocking back and forth while seated in the wheel chair in the dining room with no staff present. The resident's wheel chair was observed by the inspector to be in a straight back position. The resident's plan of care identifies that the resident's wheel chair is to be in a tilted position when unattended. The licensee did not ensure that the care set out in the plan of care was provided to the resident as specified in her plan.[s.6(7)]
3. The resident's plan of care identified the use of floor mats as an intervention in fall prevention.
The inspector observed that there were no floor mats used in the resident's room. The Registered staff on the unit where the resident resides verified that floor mats are not used in the home. The licensee did not ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.[s.6(1)(c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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Issued on this 21st day of September, 2011

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