Ontario

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

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

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

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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
September 21-23, 2010	2010_154_2604_20Sep150628	Other (Critical Incident) CI # 2604-000037-10 and 2604-000040-10 Log # S-00088 and S-00112

Licensee/Titulaire
Extendicare Northwestern Ontario Inc. [a subsidiary of Extendicare (Canada) Inc.], 3000 Steeles Avenue East, Suite 700, Markham ON L3R 9W2
Fax # 905-470-5588

Long-Term Care Home/Foyer de soins de longue durée
Extendicare York, 333 York Street, Sudbury ON P3E 5J3
Fax# 705-674-4281

Name of Inspector(s)/Nom de l'inspecteur(s)
Gail Peplinskie #154

Inspection Summary/Sommaire d'inspection

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The purpose of this inspection was to conduct a Critical Incident inspection regarding two Critical Incidents. During the course of the inspection, the inspector spoke with the Administrator, Director of Care for Extendicare Tendercare, registered nurses and Personal Support Workers (PSW) on one unit of the home and the spouse of one resident.

During the course of the inspection, the inspector:
-reviewed files of residents who were involved in reported Critical Incidents
- reviewed home's Responsive Behaviour Policy
-walked throughout one unit in the morning and afternoon September 21/10, morning and evening September 22/10 and morning of September 23/10
-observed resident care specific to two residents at various times during the inspection
-observed some meal services on a resident care unit including breakfast, lunch and dinner

The following Inspection Protocol was used during this inspection:
-Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

4 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, 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,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. The plan of care for a resident, states to toilet "pc (after) meals and at 1830 hrs". PSW working on evening shift Sept. 21/10 was interviewed and told the inspector that staff do not toilet the resident on evening shift and the resident wears a brief and staff change it. PSW told the inspector that the

resident is too resistive and aggressive on evening shift to toilet.

2. There is no direction in a resident's plan of care to indicate that staff are to provide a specific liquid at meals, although the inspector observed this being provided at breakfast September 23, 2010. One PSW told the inspector that this liquid is kept in the resident's room.
3. The plan of care for a resident does not indicate how to manage wandering on day shift and evening shift, when wandering is worse. The resident was observed by the inspector wandering in the hall and in and out of other residents' rooms during the inspection and according to interviews with 2 different PSW, this resident wanders when out of bed.
4. The plan of care for a resident does not include interventions to manage aggression. Documentation in the health care record since August 1/10 indicates that the resident has had aggressive episodes with staff and other residents. Staff report that the resident is physically aggressive with staff and residents.
5. The plan of care for the resident does not include interventions to manage the risk for falls. Documentation in the health care record indicates that the resident has had nine falls when out of bed, since July1/10.
6. 2 PSW interviewed indicated that one of the residents involved in the Critical Incident is resistive and aggressive during the provision of care and evening staff provide care with 2 staff at all times. This is not identified in the resident's plan of care.

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WN #2: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.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,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

Finding:

1. The plan of care for a resident admitted approximately 3 months ago, has not been revised to address changes in their care needs. Subsequent to admission, the resident has had nine documented falls between July 1/10 to date of this inspection. The plan of care does not address this problem when resident is out of bed.
2. The plan of care for a resident has not been revised to address interventions to manage responsive behaviours related to wandering and provision of care. PSW staff reported to inspector during inspection that the resident wanders into other residents' rooms and is physically aggressive with staff and residents and exhibits other inappropriate behaviours.
3. The plan of care for a resident has not been revised to include the need for 2 staff to provide care on evening shift. PSW staff reported during interviews that, on evening shift, the resident requires 2 staff to provide care due to responsive behaviour/aggression.

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WN #3: The Licensee has failed to comply with 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.

Finding:

1. During the inspection, the inspector observed that care, related to adaptive devices, identified in a resident's plan of care was not provided during one meal on September 22/10.

2. During the inspection, the inspector observed that care, related to meal service, identified in a resident's plan of care was not provided on September 22/10.
3. During the inspection, the inspector observed that care, related to staff assistance, was not provided throughout a meal on September 22/10.

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WN #4: The Licensee has failed to comply with O.Reg. 79/10, s.26(3). A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
(5) mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Finding:

1. The plan of care for a resident does not address the following:
   - responsive behaviors when staff perform personal care
   - resident's resistance to care, especially on evening shift
   - 2 staff frequently required on evening shift to provide care due to resistive behaviour as reported by two PSW on evening shift
   - risk for injury from other residents due to wandering into other residents' rooms and potential behavioural triggers
   - variations in resident functioning on day shift versus evening shift
   - interventions to address wandering on unit, into other residents' rooms and in dining room during meal service

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Faxed to Licensee Oct 18/10. **Title:** **Date:**	**Date of Report:** October 18/10.