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
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 24, 30, 2011; Feb 18, 20, 23, 2012	2011_051106_0010	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

MARGOT BURNS-PROUTY (106)

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 (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN),Personal Support Workers (PSW), Physical Therapy Assistant (PTA) and Residents.

During the course of the inspection, the inspector(s) conducted a walk through of resident home areas and various common areas, observed resident care, observed staff practices and interactions with residents, reviewed resident health care records, policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. A resident fell and was transferred to hospital for assessment. On August 25, 2011 at 1235 hours, full-time RPN providing care for the resident told inspector 106 that they were not familiar with the resident's plan of care in regards to transfers or falls prevention. The licensee failed to ensure that staff and others who provide direct care to the resident are kept aware of the contents of the plan of care and have convenient and immediate access to it. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (8)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. On August 25, 2011, inspector 106 observed the call bell for a resident, clipped to cord on wall behind the resident's bed. When the resident was asked where their call bell was in case they need to call the nurse the resident stated that they "do not have one of those". A staff member was then asked if the resident was able to use their call bell they stated, they were and that it should be in reach of the resident. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
2. On August 25, 2011, inspector 106 observed, a resident asleep in bed, the call bell was clipped to its own cord where it exits the wall and not easily accessible for the resident. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
3. On August 25, 2011 at 1407 hours, inspector 106 observed a resident reclined in their wheelchair near the door, in their room. The call bell for the resident was clipped to the bed rail on the opposite side of bed and not easily accessible to the resident. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
4. On August 25, 2011 at 1919 hours, a resident was observed by inspector 106 asleep in their wheelchair near the door of their room. The call bell for the resident was clipped to the pillow on the bed behind the resident. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times. [O. Reg. 79/10, s. 17 (1) (a)] (106)
5. On August 25, 2011 at 1403 hours, inspector 106 observed a resident in their room, tilted back in their wheelchair. The call bell for the resident was clipped to head of bed behind and out of reach of the resident. The licensee failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times.[O. Reg. 79/10, s. 17 (1) (a)] (106)

WN #3: 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 subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
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.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On August 24, 2011 at 1005 hours on the 4th floor, inspector 106 observed a resident, who was in a wheelchair ask a Physiotherapy Assistant (PTA), to tie their shoe. The PTA responded by saying "you don't need your shoe tied it is Velcro". The resident responded that the right shoe was loose. The PTA stated "can't you do it". The resident stated that they could not bend down. The PTA did not respond to this and portered residents into the elevator and left the unit. The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 1] (106)
2. On August 23, 2012 at 1622 hours, inspector 106 heard the call bell ringing for a resident. A PSW was observed to enter the room and turn the call bell off. The same PSW was overheard telling the RPN that the resident wanted up and that they told the resident, they would come and get them up later. At 1648 hours the resident was still in bed and had fallen asleep when inspector 106 left the unit. The most recent RAI- MDS assessment for the resident, indicates they requires extensive assistance and 2 person physical assist for transfers. The licensee failed to ensure that the resident's right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with their needs was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 4] (106)
3. On August 23, 2011 at 1615 hours, inspector 106 observed from the hallway, two PSWs transferring a resident, with a lift. Two residents were in the hall near the resident's door as the resident was being transferred. The licensee failed to ensure that the resident's right to be afforded privacy in treatment and in caring for their personal needs was fully respected and promoted. [LTCHA, 2007, S. O. 2007, c. 8, s. 3 (1) 8] (106)

Issued on this 24th day of February, 2012

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