Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2011_029134_0003
Type of Inspection / Genre d'inspection:	Critical Incident
Date of Inspection / Date de l'inspection :	Jul 4, 5, 6, 7, 8, 12, 13, 14, 15, 19, 20, 21, 22, 27, 28, 2011
Licensee / Titulaire de permis :	EXTENDICARE NORTHWESTERN ONTARIO INC 333 York Street, SUDBURY, ON, P3E-4S4
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	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 # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 6. The compliance plan shall include how the licensee will ensure that the written plan of care for each resident, who is at risk of falls; 1. will provides clear directions to staff; 2. that the care set out in the plan will be provided to the resident and, 3. that the plan of care will be reviewed and revised when not effective and that different approaches are considered in the revision of the plan.

This plan must be submitted in writing to Inspector Colette Asselin at 347 Preston Street, 4th, Ottawa ON K1S 3J4 or by fax at 1-613-569-9670 on or before August 5, 2011. Full compliance with this order shall be by September 9, 2011.

Grounds / Motifs :

1. The licensee has failed to comply with s.6 (1), (7), and (11), in that it failed to provide clear direction to staff: failed to provide care as set out in the plan; failed to revise the plan of care when ineffective and to consider different approaches in the revision of the plan.

2. On one evening shift, one resident was taken to the toilet by the assigned PSW even though the resident had been found to be lethargic and leaning toward the left side. While sitting on the toilet the resident slid and fell over onto the left side and onto the floor. When interviewed about the incident the PSW, indicated she did not receive clear directions related to this resident's change in condition and was unaware of the extent of the assistance required by the resident during transfers. [s.6 (1)]

3. The PSW, who was on duty the night shift following the fall off the toilet, was interviewed and she stated she did not receive clear direction prior to providing 1:1 supervision to the resident. She said, she was not told the resident had fallen on the previous evening shift, which had occurred only one hour prior to her shift. She did not receive additional directions regarding the resident's care needs that night, other than sitting by the resident's side. [s.6(1)]

4. As a result of the resident's restlessness and high risk of falling, his plan of care was revised to include 1:1 supervision. The resident fell as a result of not being supervised. Based on review of the progress notes and discussion with the DOC there was a gap of one hour before someone could provide the 1:1 supervision that day. No alternative measures were planned to ensure the resident's safety during the one hour gap. The licensee failed to ensure that care set out (1:1 supervision) in the plan of care was provided to the resident. [s.6 (7)]

5. There is an entry in the progress notes on the same date specifying the resident had vomited twice after an unwitnessed fall. Gravol and Stemetil were then given as per the medical directive. There is no indication in the progress notes linking the symptoms of nausea and vomiting to a possible head injury. The doctor was not notified and the resident was not sent to hospital for further assessment, following symptoms of nausea and vomiting. That evening the nurse simply noted in progress notes "to monitor, will continue to follow". The licensee failed to ensure that different approaches were considered in the revision of the plan. These could have included, increasing the neurological signs and vital signs monitoring, calling the physician and transferring the resident to hospital. [s.6 (11)]

6. There are several entries in the progress notes indicating the resident's condition was changing significantly but these changes were not reported to the physician as per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03. This policy requires the immediate notification of the physician and or transfer to hospital if the resident is exhibiting decrease in consciousness, deficits in physical abilities, fixed dilated pupils changes in vital signs. [s. 6(11)]

7. On one occasion the resident was examined by the DOC and the RN and was found to be difficult to arouse with "pinpoint" pupils and to have fresh bruising to the left side of his neck. As per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03, the immediate notification of the physician and or transfer to hospital is required if the resident is exhibiting fixed dilated pupils. The RN returned to reassess the resident at which time the resident was unable to be aroused. The resident was send to the hospital. The licensee failed to consider different approaches in the revision of the plan of care. [s.6 (11)] (134)
(134)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2011

Order # /
Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with s. 19, to ensure actions are taken to protect newly admitted residents from neglect. In particular this plan shall address how to ensure there is full communication between all parties about the resident's needs and how such communication will be documented to ensure resident needs are met. Further, the plan shall include staff training to ensure policies and procedures are followed (in particular the head injury and after-hour medication protocol); training in identifying and communicating and documenting other approaches when care needs have not been effective; and training to ensure that all falls are fully investigated and accurately documented, and to ensure that the plan of care is changed accordingly and followed.

This plan must be submitted in writing to Inspector Colette Asselin at 347 Preston Street, 4th, Ottawa ON K1S 3J4 or by fax at 1-613-569-9670 on or before August 5, 2011. Full compliance with this order shall be by September 9, 2011.

Grounds / Motifs :

1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

The following six occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well being of a resident:

1. One resident was prescribed a list of medication to be administered the evening of admission. The resident did not receive them. The resident was also prescribed a list of medication to be administered at 08:00h the next morning and the resident did not receive them. The licensee failed to provide the resident's evening and morning medications as ordered.

2. A Critical incident (CI) report was sent to Ministry of Health. The description of the fall incident provided on the report did not reflect the internal incident report or the documentation entered in the resident's progress notes. The DOC reported, that she had not conducted an investigation of the fall incident in question.

3. There had been a change in the plan of care specifying that the resident needed 1:1 supervision. Later there is an entry in the progress notes indicating the resident was found on floor by a PSW. This fall was unwitnessed. Based on review of the progress notes and discussion with the DOC there was a gap of one hour before someone could provide the 1:1 supervision that day. No alternative measures were planned to ensure the resident's safety during the one hour gap. As a result of them not supervising the resident, the resident fell. The DOC reported that she did not conduct an investigation of the resident's unwitnessed fall, also.

4. Following the unwitnessed fall, there is an entry in the progress notes specifying the resident vomited twice. The resident had fallen and it is clear that no one considered that the resident might have been experiencing complications related to a possible head injury. The doctor was not notified and the resident was not sent to hospital for further assessment. That evening the nurse noted in progress notes "to monitor, will continue to follow", but nothing further. There is no indication in the progress notes linking the symptoms of vomiting to possible intracranial pressure and therefore these symptoms were not dealt with, adequately.

5. There are several entries in the progress notes indicating the resident's condition was changing significantly but these changes were not reported to the physician as per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03. This policy stipulates to call the physician or transfer resident to hospital if some of the following symptoms are observed. These include but are not limited to; decreasing consciousness, deficits in physical ability, fixed or dilated pupils. Failure to follow that procedure jeopardized the resident's health, safety and well being

6. On one occasion the resident was examined by the DOC and the RN at 08:00h and was found to be difficult to arouse with "pinpoint" pupils and to have fresh bruising to the left side of his neck. In a statement to the inspector, the RN indicated she was needed in the dining room for breakfast and did not return to reassess the resident until 10:00h. At that time she was still unable to arouse the resident and decided to send the resident to the hospital. The Nursing Staff failed to act and address the resident's serious medical needs in a timely manner between 08:00h and 10:00h.
(134)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 09, 2011

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION / RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

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 services 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: 416-327-760

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 tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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. Clair 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 29th day of July, 2011

Signature of Inspector / Signature de l'inspecteur : Colette Asseli[signature]

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

Service Area Office / Bureau régional de services : Sudbury Service Area Office

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 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
Jul 4, 5, 12, 13, 14, 15, 19, 20, 21, 22, 27, 28, 2011 & July 6, 7, 8, 2011	2011_029134_0003	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

COLETTE ASSELIN (134)

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 Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), RAI Coordinator, Pharmacist, Physiotherapy Aid, Personal Support Workers (PSW), Chaplain, Social Worker and family members.

During the course of the inspection, the inspector(s) reviewed the resident's health record, the internal incident reports, the critical incident reports sent to the Ministry of Health and Long Term Care (MOHLTC), policies and procedures related to fall prevention and head injury routines, medical directive, restraint policy, complaint form, 24-hour unit report, doctor's book and CCAC's functional assessment.

The following Inspection Protocols were used in part or in whole during this inspection:

Admission Process

Continence Care and Bowel Management

Falls Prevention

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Definitions WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Définitions 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits sayants :

1. The licensee has failed to comply with s.6 (1), (7), and (11), in that it failed to provide clear direction to staff: failed to provide care as set out in the plan; failed to revise the plan of care when ineffective and to consider different approaches in the revision of the plan.

2. On one evening shift, one resident was taken to the toilet by the assigned PSW even though the resident had been found to be lethargic and leaning toward the left side. While sitting on the toilet the resident slid and fell over onto the left side and onto the floor. When interviewed about the incident the PSW, indicated she did not receive clear directions related to this resident's change in condition and was unaware of the extent of the assistance required by the resident during transfers. [s.6 (1)]

3. The PSW, who was on duty the night shift following the fall off the toilet, was interviewed and she stated she did not receive clear direction prior to providing 1:1 supervision to the resident. She said, she was not told the resident had fallen on the previous evening shift, which had occurred only one hour prior to her shift. She did not receive additional directions regarding the resident's care needs that night, other than sitting by the resident's side. [s.6(1)]

4. As a result of the resident's restlessness and high risk of falling, his plan of care was revised to include 1:1 supervision. The resident fell as a result of not being supervised. Based on review of the progress notes and discussion with the DOC there was a gap of one hour before someone could provide the 1:1 supervision that day. No alternative measures were planned to ensure the resident's safety during the one hour gap. The licensee failed to ensure that care set out (1:1 supervision) in the plan of care was provided to the resident. [s.6 (7)]

5. There is an entry in the progress notes on the same date specifying the resident had vomited twice after an unwitnessed fall. Gravol and Stemetil were then given as per the medical directive. There is no indication in the progress notes linking the symptoms of nausea and vomiting to a possible head injury. The doctor was not notified and the resident was not sent to hospital for further assessment, following symptoms of nausea and vomiting. That evening the nurse simply noted in progress notes "to monitor, will continue to follow". The licensee failed to ensure that different approaches were considered in the revision of the plan. These could have included, increasing the neurological signs and vital signs monitoring, calling the physician and transferring the resident to hospital. [s.6 (11)]

6. There are several entries in the progress notes indicating the resident's condition was changing significantly but these changes were not reported to the physician as per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03. This policy requires the immediate notification of the physician and or transfer to hospital if the resident is exhibiting decrease in consciousness, deficits in physical abilities, fixed dilated pupils changes in vital signs. [s. 6(11)]

7. On one occasion the resident was examined by the DOC and the RN and was found to be difficult to arouse with "pinpoint" pupils and to have fresh bruising to the left side of his neck. As per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03, the immediate notification of the physician and or transfer to hospital is required if the resident is exhibiting fixed dilated pupils. The RN returned to reassess the resident at which time the resident was unable to be aroused. The resident was send to the hospital. The licensee failed to consider different approaches in the revision of the plan of care. [s.6 (11)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits sayants :

1. Ontario Regulation 79/10, made under the Long Term Care Homes Act, 2007, defines "neglect" as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well being of one or more residents.

The following six occurrences demonstrate a pattern of inaction that jeopardized the health, safety and well being of a resident:

1. One resident was prescribed a list of medication to be administered the evening of admission. The resident did not receive them. The resident was also prescribed a list of medication to be administered at 08:00h the next morning and the resident did not receive them. The licensee failed to provide the resident's evening and morning medications as ordered.

2. A Critical incident (CI) report was sent to Ministry of Health. The description of the fall incident provided on the report did not reflect the internal incident report or the documentation entered in the resident's progress notes. The DOC reported, that she had not conducted an investigation of the fall incident in question.

3. There had been a change in the plan of care specifying that the resident needed 1:1 supervision. Later there is an entry in the progress notes indicating the resident was found on floor by a PSW. This fall was unwitnessed. Based on review of the progress notes and discussion with the DOC there was a gap of one hour before someone could provide the 1:1 supervision that day. No alternative measures were planned to ensure the resident's safety during the one hour gap. As a result of them not supervising the resident, the resident fell. The DOC reported that she did not conduct an investigation of the resident's unwitnessed fall, also.

4. Following the unwitnessed fall, there is an entry in the progress notes specifying the resident vomited twice. The resident had fallen and it is clear that no one considered that the resident might have been experiencing complications related to a possible head injury. The doctor was not notified and the resident was not sent to hospital for further assessment. That evening the nurse noted in progress notes "to monitor, will continue to follow", but nothing further. There is no indication in the progress notes linking the symptoms of vomiting to possible intracranial pressure and therefore these symptoms were not dealt with, adequately.

5. There are several entries in the progress notes indicating the resident's condition was changing significantly but these changes were not reported to the physician as per the home's "Neurological Signs/Head Injury Routine procedure # 08-08-03. This policy stipulates to call the physician or transfer resident to hospital if some of the following symptoms are observed. These include but are not limited to; decreasing consciousness, deficits in physical ability, fixed or dilated pupils. Failure to follow that procedure jeopardized the resident's health, safety and well being

6. On one occasion the resident was examined by the DOC and the RN at 08:00h and was found to be difficult to arouse with "pinpoint" pupils and to have fresh bruising to the left side of his neck. In a statement to the inspector, the RN indicated she was needed in the dining room for breakfast and did not return to reassess the resident until 10:00h. At that time she was still unable to arouse the resident and decided to send the resident to the hospital. The Nursing Staff failed to act and address the resident's serious medical needs in a timely manner between 08:00h and 10:00h.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs
Specifically failed to comply with the following subsections:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits sayants :

1. The following findings show the licensee did not comply with s. 131 (1) and (2) related to the prescribing and administration of drugs.

2. A newly admitted resident, was prescribed medication to be administered on the evening shift. The resident did not receive them. The resident was prescribed medication to be administered at 08:00h the next morning and the resident did not receive them.

3. As per a statement from the pharmacist to the inspector, the licensee did not use the after-hour pharmacy to fill the resident's prescription as per their policy.

4. On one evening the resident received Gravol and Stemetil for vomiting. These medications were not prescribed for the resident.

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 newly admitted residents receive their medication as per the directions for use as specified by the physician, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits sayants :

1. The licensee has failed to comply with s. 55 (b) related to advising direct care staff at the beginning of every shift of each resident's behaviors, which require heightened monitoring.

2. On one evening shift, the PSW, who was hired specifically to provided 1:1 supervision to the resident, for restlessness, agitation and risk of falls, indicated she was not advised at the beginning of the shift of the resident's behaviors that required heightened monitoring.

3. The PSW, who was hired specifically to provide 1:1 supervision to the resident, on a different shift, stated she was not advised about the resident's behaviors of restlessness, agitation and risk of falls, that required heightened monitoring.

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 by ensuring that direct care staff are advised at the beginning of each shift of the resident's behaviors that pose a risk to themselves and to others, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits sayants :

1. The following instances show the licensee failed to comply with s. 117 (b) to ensure that no medical directives for the administration of a drug is used unless it is individualized to the resident's condition and needs.

2. The licensee's Policy # 11-05, dated April 12, 2011, related to Medical Directive was reviewed. This policy specifies, "there is only one Medical Directive document in the home, which is used for all residents. The Registered Nurse may implement the Medical Directive. She is to accept accountability for deciding that the particular procedure is required and for ensuring that any potential outcomes are managed appropriately".

3. The Medical Directive provides a list of medical conditions with indications for administering the medication or treatment. It is indicated that the registered nurse will select the drug of choice depending on the resident's symptoms or needs and will administer the medication to the resident. This medication is then transcribed in the "Physician's Order" sheet. The attending physician is expected to sign for the medical directive at his next visit, after the medication was administered.

4. One resident reportedly vomited several times after an unwitnessed fall. Following these episodes, Gravol and Stemetil was administered, from a medical directive that was not individualized to the resident's needs. These medications were not prescribed for the resident.

5. During the home inspection the inspector noted the orders for Gravol and Stemetil, that had been administered to the resident earlier had not been signed yet, by the attending physician, as per the home's Medical Directive's policy.

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 no medical directives or orders for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).

Findings/Faits sayants :

1. The licensee failed to comply with s. 107(5), to promptly notify the Substitute Decision Maker (SDM) of a serious injury of a resident.

2. A resident sustained a laceration to left elbow, which was bleeding profusely and noted to have a protrusion at the left hip after falling in the night. These injuries are serious. The resident was sent to hospital later in the day and the SDM, was not promptly notified.

3. The resident sustained an unwitnessed fall and as part of the head injury policy the neurological signs and head injury routine procedure # 08-08-03 was initiated. The resident vomited several times after the fall. The vomiting was not resolved with Gravol. The SDM was not notified, following the resident's persisting vomiting, which could have been a possible serious consequence of a head injury, post fall.

4. On another occasion, the resident fell off the toilet on the evening shift. The next morning the resident was difficult to arouse, with pinpoint pupils and bruising to the left side of his neck. The SDM was not promptly notified of the serious injuries until 10:00h. In the circumstances of the history of falls by this resident and the symptoms this resident was showing, this amounted to be a serious injury and the SDM should have been notified earlier.

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 residents' Substitute Decision Makers (SDM) are promptly notified of a serious injury or serious illness of residents, in accordance with any instructions provided by the person who is so identified, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following subsections:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

s. 24. (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 to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

Findings/Faits sayants :

1. The licensee failed to comply with s. 24(4) in that the licensee failed to ensure that the plan of care was based on the needs of the resident in that his plan of care specified to provide oversight when walking, when in fact the resident was unable to walk. The written plan of care was partially revised to indicate resident was to use a wheelchair temporarily, however the plan of care still instructed staff to provide oversight when walking. [s.24(4)]

2. The licensee has failed to comply with s. 24 (5) in that, one resident was ordered a new medication. The SDM claims he was not told about the order and did not give his consent. There is no indication in the progress notes that he was made aware of the new order. The SDM was not given the opportunity to participate fully in the development of the resident's plan of care. [s.24(5)]

Issued on this 29th day of July, 2011

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
Colette Asselin, #134