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

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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
Apr 2, 3, 4, 5, 11, 12, 2012	2012_051106_0009	Critical Incident

Licensee/Titulaire de permis

EXTENDICARE ~~NORTHWESTERN ONTARIO~~ (Canada) 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), Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Janitor, and Residents

During the course of the inspection, the inspector(s) Conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home and reviewed resident health care records

The following Inspection Protocols were used during this inspection:

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

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The RAI MDS assessment for a resident, under section "G" transfers, identifies that they require "limited assistance and the physical assistance of 2 staff persons". The "EO Resident Transfer/ Lift Assessment' identifies that the resident transfers with one person. The plan of care for the resident indicates that they are "a one person transfer" and PSWs interviewed also state that the resident requires the assistance of one staff person to transfer. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other. [LTCHA, 2007, S. O. 2007, c. 8, s. 6 (4) (a)] (106)

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours
Specifically failed to comply with the following subsections:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. On April 4, 2012 during an interview with the DOC, they stated that a resident routinely becomes agitated if they do not want to take their medication and staff attempt to press the matter. The plan of care does not contain any strategies that direct staff on how to manage these behaviours, in regards to the resident becoming agitated and aggressive if pressed to take their medication. The licensee failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible. [O. Reg. 79/10, s. 53 (4) (b)] (106)
2. On April 4, 2012 during an interview with the DOC, they stated that a resident routinely becomes more active, agitated and aggressive as the day progresses. The plan of care does not contain any strategies that direct staff on how to manage these behaviours, in regards to the escalation of behaviours and the time of day. The licensee failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible. [O. Reg. 79/10, s. 53 (4) (b)] (106)
3. The "Behaviours of Daily Living" flow sheets were reviewed for a resident. In the last four months, there were 19 documented incidents of aggressive behaviour by the resident, 13 of which were documented aggression towards other residents. In the plan of care for the resident, under the behaviour section, there is a focus of "aggression toward other residents and staff", but there are no strategies developed that address their aggression towards staff or other residents. The licensee failed to ensure that strategies are developed and implemented to respond to these behaviours. [O. Reg. 79/10, s. 53 (4) (b)] (106)

Issued on this 12th day of April, 2012

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