Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 17, 2013	2013_205129_0006	H-001380-12	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE HALTON HILLS
9 Lindsay Court, Georgetown, ON, L7G-6G9

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 31 & July 15, 2013

This critical incident inspection was conducted to review care provided to a resident before and following an incident that resulted in injury to the resident. (Log #H-001380-12)

During the course of the inspection, the inspector(s) spoke with resident #001, registered and unregulated nursing staff, the Physiotherapist, the Director of Care, the Assistant Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed resident #001, reviewed clinical records, reviewed the home's staff training records and reviewed the home's policy and procedures related to: Falls Prevention and Management, Post Fall Analysis, Transfers and Pain Assessment.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé 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:

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; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the written plan of care for resident #001 set out clear directions to staff and others who provide direct care to the resident, with respect to the following: [6(1)(c)]
Resident #001 fell in 2012, resulting in the resident sustaining an injury. The resident was transferred to hospital on the same date and returned to the home at 1845hrs that evening.
a) Staff providing care to the resident confirmed that prior to the fall this resident transferred with the assistance of one staff person, could weight bear to stand, required the use of a support device, staff transferring the resident were to ensure that the resident's feet were positioned flat on the floor prior to the transfer and the risk for falling was increased because the resident would attempt to self- transfer.
Staff and clinical documentation confirmed that the written plan of care did not contain clear directions for staff with respect to:
- the use and application of the support device prior to transferring the resident
- the need to ensure that the resident's feet were positioned flat on the floor prior to assisting the resident to transfer.
- care directions with respect to reducing the risk of falling as a result of the resident attempts to self transfer without assistance.
b) Clinical documentation in the progress notes indicated that when the resident returned from hospital the resident was being treated for an infection, was on bed rest for an extended period of time, was having difficulty voiding for which the resident was order to receive a treatment and was to have a specialized stocking applied to the left leg.
Staff and clinical documentation confirmed that the written plan of care in place for the resident following return to the home did not contain clear directions for staff with respect to:
- Care directions related to monitoring symptoms of an infection and the use of antibiotics.
- Changes in the provision of care related to toileting, bathing, transfers and prevention of skin breakdown based on the resident's injury and a change in the resident's activity to bed rest.
- Care directions for the management and monitoring of changes to the resident's urinary tract function.
- Care directions for the use of a specialized stocking on the resident's left leg. [s. 6. (1) (c)]

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 and ensuring that the written plans of care for all residents set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system was complied with, in relation to the following: [8(1)(b)] The homes policy identified as [Policy:Falls] # 09-02-01 and dated July 2010 directs that when a resident falls registered staff will immediately assess the resident and that a complete head to toe exam is to be completed prior to moving the resident.
- Staff in the home did not comply with this direction when resident #001 fell to the floor while being assisted to transfer from the bed to the wheelchair on an identified date. The Personal Support Worker (PSW)attending the resident at the time of the fall called for assistance and a second PSW entered the room to provide assistance. One staff left the resident's room to alert the registered staff, however confirmed that she was unable to locate the registered staff, returned to the resident's room, assisted in moving the resident from the floor to a wheelchair and then took the resident to the dining room for breakfast. The resident was not assessed before being moved and was not assessed for at least one and a half hours after the fall. The resident was sent to the hospital where it was confirmed she had suffered a fracture. [s. 8. (1)]

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 and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise, put in place any plan, policy, protocol, procedure, strategy or system that staff comply with the plan, policy, protocol, procedure, strategy or system, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received training in falls prevention and management in accordance with O. Reg. 76/10, s. 22(1)1 on an annual basis. [76(7)6]
Information provided by the home indicated that 23 of approximately 130 staff who provide direct care to residents received training in falls prevention and management in 2011. The Assistant Director of Care confirmed that there were no records of falls prevention and training offered in the home beyond the information provided at the time of this inspection for 2011. [s. 76. (7) 6.]

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 and ensuring that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in falls prevention and management, to be implemented voluntarily.

Issued on this 13th day of August, 2013

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

Phyllis Hiltz-Bontje