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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Mar 28, 2014	2014_301561_0003	H-000443-13, H-000579-13	Complaint

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

DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 26, 27 and 28, 2014.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Associate Director of Care (ADOC), Medical Director, registered staff, Personal Support Workers (PSWs), and family.

During the course of the inspection, the inspector(s) interviewed Director of Care (DOC), registered staff, Personal Support Workers (PSWs) and family, observed the care provided to the resident, reviewed health care records, progress notes, and policies and procedures related to Falls Prevention, Resident Abuse, and Personal Assistance Service Devices.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation

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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee did not ensure that a Personal Assistance Services Device (PASD) was used to assist a resident with a routine activity of living only if the use of the PASD was included in resident's plan of care.

A. Resident #001 was observed on February 26, 2014 and was noted to have one full bed rail on one side and a half rail on the other side of bed elevated while in bed. The plan of care that directed staff related to the care for the resident, did not identify the use of bed rails. Interview with the Director of Care confirmed that bed rails were used for safety and should have been included in the plan of care.
Resident #001 was also observed on February 27, 2014 sitting in a broda chair which was tilted back. Registered staff and the Director of Care confirmed that a tilted chair for this resident is used for positioning. The plan of care that directed staff related to the care for the resident did not identify the use of a tilted chair.

B. Residents #002 and #003 were both observed to have one full bed rail on one side and a half rail on the other side of the bed applied while in bed on February 28, 2014. Registered staff and Personal Support Worker confirmed that bed rails were used for safety for both residents. The plans of care did not identify the use of bed rails for both residents. [s. 33. (3)]

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 a Personal Assistance Services Device (PASD) is used to assist a resident with a routine activity of living only if the use of the PASD is included in resident's plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee did not ensure that staff used safe transferring and positioning devices when transferring resident #001.

In June 2013, resident #001 was physically transferred by staff from the floor onto the bed without the aide of a mechanical device after a fall. Resident #001's plan of care stated that resident required a mechanical lift for transfer with two person assist. During the interview with the Director of Care related to the investigation of the incident, it was noted that staff did not use the method of transferring consistent with resident's plan of care. The interview with registered staff and the staff involved in the incident confirmed that the incorrect method of transferring was used. [s. 36.]

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 staff use safe transferring and positioning devices when transferring residents, to be implemented voluntarily.

WN #3: 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. (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 fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee did not ensure that the resident's substitute decision-makers, were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

According to the Medication Review Report from January 2013, a number of medications were discontinued for resident #001. Both Powers of Attorney (POAs) were informed of this change in treatment during the Interdisciplinary Care Conference which was held one week after medications were discontinued. POA stated they were not notified of the change in medication at the time it occurred. Furthermore, there is no documented evidence in progress notes stating that either of POAs were notified of the medication being discontinued at the time. In February 2013 progress notes by Medical Director stated that family was concerned that resident's medications were discontinued. One medication was restarted at family request. The POAs were not given an opportunity to participate fully in the development and implementation of the resident's plan of care. [s. 6. (5)]

Issued on this 4th day of April, 2014

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

DARIA TRZOS