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 1, 2, 7, Sep 4, 2012	2012_026147_0030	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

LALEH NEWELL (147)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered staff, Personal Support Workers (PSW), residents and family.

During the course of the inspection, the inspector(s) Interviewed Administrator, Director of Care (DOC),Personal Support Workers (PSW), Registered Staff, residents and families, reviewed clinical chart and progress notes, reviewed Policy and Procedure related to Medication Administration.

H-001222-12

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

Safe and Secure Home

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 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. The licensee did not ensure that the home is equipped with a resident-staff communication and response system that, 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. [s.17(1)(g)]

The home's communication and response system was not properly calibrated for staff to hear the call bells when activated on the units. The home utilizes a call bell system that uses sound through a pager system and visual lights above the resident's rooms to alert staff when a call bell has been activated. Call bells activated from resident's rooms and washrooms could only be heard at the nursing station and not through out the back hallways or on pagers. The visual cue was functioning, which consisted of a light over the resident's room door.
Interview with staff on different home areas confirmed the call bells were not audible in the home area, only at the nursing station, when activated. The staff indicated they do not carry pagers for the home's call bell system. Interview with the DOC confirmed the staff on the units do not have pagers to alert them when a call bell has been activated and only alerts the charge nurse on the unit. According to staff and families the residents spend significant amount of time for care to be provided, such as toileting as the staff do not hear the call bells when activated by residents and families.

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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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 saillants :

1. The licensee did not ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber, in relation to the following: [s.131(2)]

a. In 2012 an identified resident was administered several different medications that was not in accordance with the direction of the prescriber. The registered staff administered a co-resident's medication to the resident. According to the home's documentation the resident was transferred to hospital for further assessment and monitoring as a result of being administered the wrong medications by the registered staff.
b. This was confirmed through interviews with the registered staff and DOC, review of the internal incident report and Medication Administration Record (MAR) for both residents.

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 drugs were administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 5th day of September, 2012

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