Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2016	2016_397607_0019	017033-16, 000561-16, 014169-16, 017030-16	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 OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

JULIET MANDERSON-GRAY (607)

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): August 2, 3, 4 & 5, 2016.

During this Critical Incident Inspection, the following intake were reviewed and inspected upon Log #'s: 017033-16, 000561-16, 014169-16, 017030-16.

Summary of the Intakes:

1) Log # 014169-16 –Regarding a fall resulting in an injury and significant change.
2) Log # 017030-16 –Regarding alleged resident to resident abuse.
3) Log #000561-16 –Regarding improper and incompetent treatment of a resident that resulted in harm or risk to a resident, and significant change.
4) Log #017033-16- Regarding alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Assistant Director Care, a Social Worker, Registered Nurses (RN's), Registered Practical Nurses, (RPN's), Personal Support Workers (PSW's), Physiotherapist (PT), and a Substitute Decision Maker (SDM).

During the course of the inspection the inspector reviewed clinical health records, observed staff to resident interactions, reviewed home specific policies related to falls, zero tolerance of abuse, responsive behaviours, continence and bowel management, skin and wound and safe lifts and transfers.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
5 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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).

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).

Findings/Faits saillants :

1. 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 the planned care for the resident.

Related to Log #000561-16 for resident #002:

A Critical Incident Report (CIR) submitted to the Director indicated that on an identified date, Personal Support Worker (PSW) #103 was assisting resident #002 when he/she noted there was an injury to the resident's body part, which he/she reported to the Registered Practical Nurse (RPN). The charge nurse contacted the physician to receive orders to address the resident's discomfort and a lab test. The CIR also indicated that the resident was being managed by the home, as he/she did not required further follow-up with out patient care.

A review of the written plan of care at the time of the incident could not locate any interventions in place of how the staff would care for resident # 002's body part in relation to the resident's injury, while he/she remained in the home.

Interview with the DOC indicated that the resident injured body part was supported during the time the home managed his/her care, but the written care plan did not indicate that this intervention was in place.

Therefore, the written plan of care failed to identify the planned care for resident #002, specifically related to how to care for the resident's injury, while his/her care was being managed by the home. [s. 6. (1) (a)]

2. Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

Related to Log #017030-16 for resident #005:

A Critical Incident Report was submitted to the Director on an identified date, for an allegation of abuse/neglect incident involving resident #005.

A review of the clinical health records for resident #005 indicated that the resident was noted to exhibit several responsive behaviours that was directed towards resident #004 between an identified time period.

Interview with RPN #111 and PSW #122 indicated that resident #005 exhibited behaviours towards resident #004 and both staff were aware of the responsive behaviours towards the resident as "been ongoing for a few months." The staff were not aware of the resident's triggered behaviours interventions in place in the written plan of care to respond to the resident's behaviours.

A review of the plan of care revealed that resident #005's triggered behaviours towards resident #004 were not identified in the written plan of care until an identified date.

An interview with RPN #110 revealed that interventions related to resident #005's triggers should have been entered in the plan of care related to the resident responsive behaviours towards resident #004 prior to an identified date, and that all registered staff are responsible to ensure that written care plan is updated and implemented. He/she further indicated that the written care plan was not updated with the resident triggers until on an identified specified date.

Therefore, the licensee has failed to ensure that the written plan of care for each resident sets out the planned care for the resident, specifically related to triggered behaviours for resident #005 towards resident #004 were not implemented in the written plan of care until an identified date. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided

as specified in the plan of care.

Related to Log #000561-16 for resident #002:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, regarding an incident where a resident sustained an injury to a body part on an identified date, of unknown cause.

A review of the written plan of care in place at the time of the incident for resident #002 indicated the resident required two staff assistance for bed mobility and continence care related to: lack of mobility and physical limitations. The interventions also indicated that two staff were to reposition the resident as he/she was unable to reposition self.

The CIR indicated that PSW #103 went to provide continence care, upon turning and repositioning the resident, he/she made a noise that sounded as if there was discomfort. The PSW inspected the resident and noted that there was an injury to a body part, at which time the Registered Practical Nurse (RPN) was notified and the resident was assessed. The charge nurse then contacted the physician for orders to manage the resident's discomfort and orders for a lab test. The lab test was completed on an identified date, at which time it was determined that the resident had sustained further injury to a body part. The home did an investigation and was unable to determine the cause of the injury or when the it occurred.

Interview with PSW #103 confirmed that he/she had provided continence care and repositioned the resident by his/herself at the time the incident was discovered, the PSW further indicated that at the time he/she provided care to resident #002 it was his/her understanding that the plan of care indicated that the resident required one staff for continence care and reposition.

Therefore the licensee has failed to ensure that the care set out in the plan of care was provided to resident #002 as specified in the plan, related to continence care and bed mobility. [s. 6. (7)]

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 the resident's written plan of care sets out the planned care for the resident, and directions to staff on to how to care for a resident's body part, ensuring that the care set out in the plan of care is provided to residents related to bed mobility and continence care, specifically related to resident #002, ensuring that there is a written plan of care for each resident that sets out the planned care for the resident, specifically related to resident #005's responsive behaviour triggers, 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 has failed to ensure that the home's Safe Lift and Transfer policy is complied with.

Under O. Reg. 79/10 s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

Under O. Reg. 79/10, s.48(1)1 every licensee of a longterm care home shall ensure that the following interdisciplinary program is developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and risk of injury.

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

2. Where, under the program, staff use any equipment, supplies, devices, assisstive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

A review of the home's Safe Lift and Transfer policy with an identified date, policy #SL-08 -02-02, (page 3 of 8) directs:

Ensure all slings are inspected monthly using the monthly sling audit check.

A review of the home's clinical health records failed to locate documented record that audit of slings were completed on a monthly basis.

Interview with the DOC confirmed that an audit of the slings in the home were not completed and there is no documented record.

Therefore, the licensee has failed to ensure that it's Safe Lift and Transfer policy is complied with, specifically related to ensuring that slings are audited on a monthly basis. [s. 8. (1) (a)]

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 the home's Safe Lift and Transfer policy is complied with, to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers, to be implemented voluntarily.

WN #3: 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 has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Related to Log #014169-16 for resident #003:

A Critical Incident Report (CIR) submitted to the Director on an identified date, indicated that Personal Support Workers (PSW's) #108 and #107 was assisting resident #003 with a transfer from an assisstive device when the resident had fall sustaining an injury.

Review of resident #003's plan of care in place at time of the incident indicated that the resident required total assistance by two staff for transferring.

Interview with the DOC indicated that on an identified date resident #003 was transferred with the assistance of two staff, but the staff had breached the Safe Lifting and Transfer Policy as well as not completing safety checks before and during a transfer of a resident.

Therefore, the home has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting resident #003 with a transfer. [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 ensuring that staff use safe transferring and positioning devices or techniques when assisting residents, by ensuring staff completes safety checks before and during a transfer process, specifically related to resident #003, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon completion.

Related to Log #017033-16 for resident #001:

Critical Incident Report (CIR) was submitted to the Director on an identified date, for an allegation of staff to resident to alleged abuse/neglect for an incident involving resident #001.

Review of the licensee's investigation notes indicated the investigation was concluded an identified date and the incident of alleged abuse or neglect was not verified.

Review of resident #001's clinical health records, the incident documentation and the licensee's investigation failed to indicate that the resident or the resident's SDM were notified of the results of the investigation into the allegation of staff abuse/neglect incident towards the resident.

Interview with resident #001 and the resident's SDM indicated that they were not notified of the results of the investigation.

Therefore, the licensee has failed to ensure that the resident and resident’s SDM were notified of the results of the alleged abuse or neglect investigation immediately upon completion, specifically related to resident #001. [s. 97. (2)]

2. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log #017030-16 for resident #005:

Critical Incident Report (CIR) was submitted to the Director on an identified date, for an allegation of abuse/neglect for an incident involving resident #005.

Review of resident #005’s clinical health records, failed to indicate that the resident or the resident's SDM were notified of the outcome of an investigation into the allegation of abuse involving resident #005.

Interview with the DOC confirmed that resident #005's SDM was notified of the initial investigation, but was not notified of the outcome of the investigations related to the above identified incident of abuse.

Therefore, the licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion, specifically related to resident #005. [s. 97. (2)]

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 ensuring that the resident and resident's SDM are notified of the results any alleged abuse or neglect investigation immediately upon completion, specifically related to resident #001 and #005, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included whether a family member, person of importance or SDM of any resident(s) involved in the incident

was contacted and the name of such person or persons.

Related to Log #017030-16 for resident #005:

Critical Incident Report (CIR) was submitted to the Director on an identified date, for an allegation of abuse/neglect for an incident involving resident #005.

A review of investigation notes and CIR failed to included the name of resident #005's SDM regarding an allegation of abuse incident involving the resident.

Interview with the DOC confirmed that resident #005's SDM was notified of the above identified incident but the name of the resident's SDM was not included in the CIR submitted to the Director.

Therefore, the licensee has failed to ensure that the report to the Director included whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons, specifically related to resident #005. [s. 104. (1) 3.]

2. The licensee has failed to ensure that when a report is provided within 10 days to the Director, a follow up final report is made within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log #017033-16 for resident #001:

Critical Incident Report was submitted to the Director on an identified date , for an allegation of abuse/neglect for an incident involving resident #001.

A review of the CIR submitted to the Director on an identified date failed to indicate that a final report was made to the director within 21 days of submission.

An interview with the DOC indicated that the CIR was not updated in the specified time period to the Director.

Therefore, the licensee has failed to ensure that when a report is provided within 10 days to the Director, a follow up final report is made within the time specified by the Director, in 21 days unless otherwise specified by the Director, specifically related to resident #001. [s. 104. (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 ensuring that the report to the Director included whether a family member, person of importance or SDM of any resident(s) involved in the incident was contacted and the name of such person or persons, specifically related to resident #005, ensuring that when a report is provided within 10 days to the Director, a follow up final report is made within the time specified by the Director (in 21 days unless otherwise specified by the Director), specifically related to resident #001, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital.

Related to Log #014169-16 for resident #003:

Critical Incident Report was submitted to the Director on an identified date, for an improper transfer resulting in injury and the resident being transferred to hospital, involving resident #003.

Review of the resident #003's Weekly Impaired Skin Integrity Assessment - V 3, with an identified date identified the resident had multiple altered skin impairments.

A review of the home's Skin and Wound Program: Prevention of Skin Breakdown Policy # RC-06-12-01, dated July 2016, (page 1of 9) directs:

A residents with a Pressure Ulcer Risk Scale Score (PURS >1) greater than one will be considered at risk of altered skin integrity and is to receive a comprehensive head to toe skin assessment by a nurse upon return from hospital.

A review of resident #003's outcome assessment scores identified the resident as having a PURS score of five.

A review of the written care plan for the period for specific time period, revealed that resident #003 is high risk for altered skin integrity.

A review of the resident assessment records failed to locate that a skin assessment was completed for the resident upon return from hospital on an identified date.

Interview with RN #109 and the DOC indicate that a skin assessment was not completed for resident #003 upon return from hospital.

Therefore, the home has failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return from hospital, specifically related to resident #003. [s. 50. (2) (a) (ii)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written report include analysis and follow-up action, including:
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.

Related to Log #014169-16 for resident #003:

Critical Incident Report submitted to the Director indicated that on an identified date, Personal Support Workers (PSW's) #108 and #107 was assisting resident #003 with a transfer from transfer device when the resident fell, sustaining an injury.

A review of the CIR submitted on an identified date, failed to indicate what long term action were put in place to prevent recurrence and what immediate actions have been taken to prevent further recurrence related to the above identified incident.

Interview with the DOC confirmed that he/she did not update the Critical Incident Report to include analysis and follow-up related actions taken.

Therefore the licensee has failed to ensure that the written report to the Director include include the immediate actions that have been taken to prevent recurrence, as well as the long-term actions planned or in place to correct the situation and prevent recurrence, specifically related to the incident involving resident #003 and an injury. [s. 107. (4) 4.]

Issued on this 11th day of August, 2016

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

Original report signed by the inspector.