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

Division des foyers de soins de longue durée
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
Mar 1, 2017	2017_598570_0004	000163-17, 000770-17, 002270-17	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

SAMI JAROUR (570)

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): February 7-10, 2017

During the course of this inspection, the following Logs were inspected:
- Log #000163-17, re : Fall of resident and transfer to hospital,
- Log #000770-17, re : Fall of resident and transfer to hospital,
- Log #002270-17, re: Staff to resident alleged verbal abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator; the Director of Care (DOC); the Assistant Director of Care (ADOC); Registered Nurses (RN); Registered Practical Nurses (RPN); Personal Support Workers (PSW); Physiotherapist; and Residents.

Inspector also reviewed clinical health records of identified residents, licensee's investigation notes, observed staff to residents interactions.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 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. (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. The licensee failed to ensure the plan of care was provided to residents #002 as specified in the plan related to falls prevention and management.

Related to Log # 000770-17

A critical incident report (CIR) was received by the Director regarding a fall incident involving resident #002.

Resident #002 had a diagnosis that includes cognition impairment. The resident had been identified at risk for falls.

Review of the CIR notes and progress notes for resident #002 indicated:
On a specified date and time: resident #002 was found sitting on floor in the bedroom. The resident was assessed and assisted back to bed.
Later that day, resident #002 complained of pain and bruising was noted of a body part. The resident was sent to hospital for further assessment and diagnosed with an injury to an identified body part.

Review of resident #002's plan of care, in effect at date of incident indicated:
- identified risk for falls due to poor insight into safety awareness
- Alarm when in bed and fall mats on floor to maintain safety as the resident does not know their own limits

On February 7, 2017 interview with the ADOC indicated to the inspector that resident #002 did not have fall mats on both sides of the bed. The resident had a fall mat on one side of the bed and was found on floor on the other side of bed.

Interview with PSWs #103 and 104 indicated the resident can self-transfer from bed on both sides and prior to the fall incident, the resident had only one fall mat on one side of the bed.

Interview with RPN #105 indicated that the resident was assessed following the fall incident and that the resident was found on the floor with no fall mat in place on that side of the bed. The RPN indicated that the resident should have fall mats on both sides of the bed.

Therefore resident #002 was not provided care as specified in the plan of care related to the use of fall mats, as part of the falls management interventions for the resident. [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 by ensuring that resident #002 is provided care as specified in the plan of care in relation to falls prevention and management, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home:
2. An unexpected or sudden death, including a death resulting from an accident or suicide.

Related to Log # 000163-17

A critical incident report (CIR) was received by the Director on an identified date, three days following a fall incident involving resident #001. The CIR indicated resident #001 sustained a fall and was transferred to hospital. The resident had suffered multiple injuries to a body part.

Review of the CIR and progress notes for resident #001 indicated that the licensee was notified that resident #001 was deceased at the hospital on the same day of the fall incident.

Interview with the Director of Care (DOC) and the Assistant Director of Care (ADOC) both indicated that the death of resident #001 should have been immediately reported to the Director.

The Director was not notified of resident #001's death until three days after the incident when a CIR was submitted notifying the Director of the fall. [s. 107. (1)]

Issued on this 1st day of March, 2017

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

Original report signed by the inspector.