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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2019	2019_665551_0014	011917-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

MEGAN MACPHAIL (551)

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): July 9, 10 and 11, 2019.

The following log was inspected:
011917-19 related to concerns about the care of a resident.

During the course of the inspection, the inspector(s) spoke with the Registered Dietitian, Registered Nursing Staff, a Personal Support Worker, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed a specified resident and the resident's home area. The inspector reviewed the resident's health care record, selected policies and procedures and the home's investigation notes.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **1 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	Légende 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other.

On a specified date at a specified time, resident #001's blood glucose was elevated.

In an interview with RN #100, the RN stated that if a resident's blood glucose reading is greater than 20mmol/L, the standard process is to phone the physician.

The home's policy titled Diabetes Management - Hyperglycemia (RC-24-01-03) directs staff to notify the physician/nurse practitioner of signs and symptoms of hyperglycemia accompanied by a blood glucose reading of greater than 20mmol/L.

A review of the resident's health care record indicated that no additional measures were taken on a specified date when the resident's blood glucose was elevated, and the physician should have been notified as per RN and policy.

[log 011917-19] [s. 6. (4) (a)]

2. The licensee has failed to ensure that the care set out on the plan of care was provided to resident #001 as specified in the plan.

On a specified date, resident #001 had a fall. The resident refused to have their vital signs taken immediately after the fall.

Post fall vital signs once a shift for seventy two hours was initiated on the electronic Medication Administration Record (eMAR).

There is no indication in the eMAR, progress notes or vital signs section of the resident's chart, that the resident's vital signs were taken or that the resident refused to have them taken, on the evening shift of a specified date.

[log 011917-19] [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 that staff involved in the different aspects of resident #001's care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and compliment each other; and to ensure that the care set out on the plan of care is provided to resident #001 as specified in the plan., to be implemented voluntarily.

Issued on this 19th day of July, 2019

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

Original report signed by the inspector.