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
Dec 6, 2018	2018_605213_0026	028723-18	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 London
860 Waterloo Street LONDON ON N6A 3W6

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

RHONDA KUKOLY (213)

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): December 3, 4, 5, 2018.

This inspection was completed related to complaint log #028723-18 regarding a care concerns.

The resident involved in this complaint and content related to this complaint were also inspected during the Resident Quality Inspection #2018_607523_0006, log #005380-18, completed April 25 to May 2, 2018. A written notification was issued related to O.Reg. 79/10, s. 131(2), medication administration; specifically a medication incident that was also related to the resident in this complaint.

This inspection was completed onsite while completing a concurrent critical incident inspection #2018_605213_0025 regarding an incident with a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Clinical Coordinator, the Social Worker, the Food Services Manager, Registered Nurses, Registered Practical Nurses, a Personal Support Worker and residents.

The Inspector also made observations and reviewed health records, education records, policies and procedures, incident reports, meeting minutes and other relevant documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration

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. (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 the care set out in the plan of care was provided to the resident as specified in the plan.

A complaint was received by the Ministry of Health and Long Term Care, Long Term Care Inspections Branch regarding diagnostic testing for a resident in the home.

The health records for the resident were reviewed. The resident had a physician's order for diagnostic testing and medication related to the identified test. Part of the order indicated for results above an identified level on two occasions, contact an identified physician for further orders.

Test results documented in vitals signs and in two months of electronic Medication Administration Records (eMAR) in Point Click Care showed twice on one date, as well as two other dates, that the results were above the identified level.

There was no documentation in the health record related to contact or communication with the identified physician or department.

In an interview with the Director of Care (DOC), the Inspector asked what the order meant when it stated: for a result above an identified level on two occasions, contact the identified physician for further orders; was it twice in a row, twice in 24 hours, or twice in any period of time? The DOC said that the order was not clear and should have been clarified. When asked if the identified physician had been contacted when the test results were over the identified level on four occasions, the DOC said no. The DOC said that the registered staff contacted the resident's attending family physician, who advised that they were the most responsible person to be contacted and changed the medication orders.

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan when the home did not contact the identified physician after the resident had test results over the identified level on four occasions. [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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 7th day of January, 2019

[redacted]

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

Original report signed by the inspector.