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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 18, 2013	2013_186171_0016	L-000204-13	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

ELISA WILSON (171)

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): April 18, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care, Clinical Coordinator, Registered staff, 2 Personal Support Workers, Physiotherapist, Restorative Care Manager and resident's family.

During the course of the inspection, the inspector(s) reviewed the plan of care for an identified resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had not ensured the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

a) A resident was observed using a specific intervention, however this intervention was not included in the written plan of care. The Director of Care confirmed when this intervention is being used there should be a physician's order and the directions for use should be included in the plan of care. It was confirmed the resident had been using this intervention for six days. A review of the resident's paper and computerized chart revealed there was no physician order and the plan of care had not been revised when the resident's care needs changed.

b) A resident was observed using a specific intervention for safety. A review of the flow sheets revealed the resident had been using this intervention for three weeks. The resident's current plan of care did not indicate the correct intervention for safety. The Director of Care confirmed the expectation that the plan of care should have been reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

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Issued on this 18th day of April, 2013

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