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 # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2018	2018_650565_0005	007620-18	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 Mississauga
855 John Watt Boulevard MISSISSAUGA ON L5W 1G2

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

MATTHEW CHIU (565)

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 26, 30, and May 1, 2018.

A Critical Incident Intake related to a resident's identified medical condition was inspected.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Coroner, Registered Nurses, Registered Practical Nurses, Personal Support Workers and Residents.

The inspectors conducted observations of staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention

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	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 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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

In accordance with O. Reg. 79/10, s. 30 (1) 1, the licensee is required to ensure that there is 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.

Review of the home's policy titled "Falls Prevention and Management Program" #RC-15-01-01, last updated date of February 2017, revealed the post-fall management for resident having or suspected having a specified injury, a specified monitoring record should be completed according to the specified time periods.

A Critical Incident Report submitted to the Ministry of Health and Long Term Care indicated resident #001 fell on an identified date and time. Staff assessed the resident and initiated the specified monitoring record after the fall. At an identified time, resident #001 was found with a specified condition and identified actions were taken. Subsequently, resident #001 sustained the identified medical condition in the nursing home.

Record review indicated the above fall had happened. Resident #001 was monitored on the identified dates and times after the fall. The monitoring records were not completed according to the specified time periods of the above mentioned home's policy.

Interview with Personal Support Worker (PSW) #101 indicated they received the shift report for resident #001's fall and had been monitoring the resident on their shift after the fall. At an identified time after the last monitoring record, PSW #101 stated an identified interaction with resident #001 and then left the resident.

Interview with RN #100, RPNs #102 and #105 indicated staff should use the specified monitoring record when a resident has or suspected to have the specified injury. RPN #102 stated it should be done at the specified time periods as mentioned in the home's policy.

RPN #102 further stated they assessed resident #001's vital signs and completed the monitoring records, and confirmed no further monitoring was completed after the last entry. [s. 8. (1) (a),s. 8. (1) (b)]

2. Review of resident #002's identified medical records revealed the resident had specified health conditions and had an unwitnessed fall on an identified date and time. The specified monitoring record was initiated and completed by staff on the identified dates and times which were not following the specified time periods of the above mentioned home's policy.

Interview with the Director of Care (DOC) indicated the home's Fall Prevention and Management policy directs staff to use the specified monitoring record following the specified time periods. The DOC confirmed the specified monitoring records for resident #001 and #002 had not been completed as required by the home's policy. [s. 8. (1) (a),s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

Issued on this 15th day of June, 2018

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

Original report signed by the inspector.