Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 21, 2020	2020_643111_0003	013309-19	Critical Incident System

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 Peterborough
860 Alexander Court PETERBOROUGH ON K9J 6B4

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

LYNDA BROWN (111)

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): December 18 to 20, 2019

A critical incident inspection (CIR) (Log #013309-19) was inspected related to a fall that resulted in an injury for which the resident was sent to hospital and resulted in a significant change in condition.

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

During the course of the inspection,the inspector reviewed the health care record of a deceased resident.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions including risk of falls.

A critical incident report (CIR) was submitted to the Director for a fall incident, that resulted in a significant change in condition. The CIR indicated the resident was diagnosed with an injury to a specified area and passed away the following day.

Review of the health care record for resident #001 indicated the resident was admitted with a history of an injury to a specified area. The resident was ambulatory with use of a mobility aid.

Review of the current written plan of care for resident #001 indicated there was no planned care related to falls.

Review of the progress notes for resident #001 related to falls, from time of admission, indicated the resident had sustained a number of falls on specified dates. A number of days after the last fall, the resident had a significant change in condition, complained of pain to a specified area. The physician and family were notified and an in house diagnostic test was ordered. The resident was diagnosed with an injury to a specified area and the resident was placed on palliative care. The resident passed away the following day.

During an interview with the DOC, they indicated the expectation was when a resident sustained a fall, the RN assesses the resident, completed post fall assessments, notify the family and physician and then update the residents written care plan. The DOC confirmed the resident's written care plan was considered the plan of care and should have been updated after the resident had sustained a number of falls.

The licensee has failed to ensure that the plan of care for resident #001 was based on an interdisciplinary assessment with respect to the resident's health conditions including, risk of falls.

Issued on this 28th day of January, 2020

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

Original report signed by the inspector.