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
Dec 8, 2021	2021_931821_0002	015896-21	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 Port Stanley
4551 East Road Port Stanley ON N5L 1J6

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

PETER HANNABERG (721821), KRISTEN MURRAY (731)

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 3, and 6/2021

The following Critical Incident intakes were completed within this inspection:

Related to falls prevention: Critical Incident Log #015896-21 / CI 2669-000006-21

An IPAC inspection was also completed at the time of the Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with a Housekeeper, a Screener, Personal Support Workers (PSW), a Registered Practical Nurse (RPN), the Dietary Manager, and the Administrator/Director of Care. The Inspectors also conducted observations of residents and staff. The Inspectors also reviewed residents' plan of care, progress notes, assessments, and the home's Falls Management policy.

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

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's plan of care included clear directions related to falls prevention and management interventions.

In separate interviews with a Personal Support Worker (PSW) and Registered Practical Nurse (RPN), each staff member stated that the resident required specific interventions related to falls management. Upon review of the plan of care, one of the interventions was not identified for the resident, who was at high risk for falls.

The home's Falls Prevention and Management Program Policy (RC-15-01-01, updated December 2020) states on page three that an interdisciplinary team is required to flag residents who need additional precautionary measures, and these should be clearly communicated to all parties.

The Administrator/Director of Care (DOC) reviewed the resident's plan of care and confirmed that a specific falls management intervention should have been included within the plan of care as part of the falls management interventions, however it was missing. The resident could have been at risk for injury if the direct care staff were not aware of the need to provide the specified intervention.

Sources: Interviews with PSW, RPN, and Administrator/DOC; Falls Policy (RC-15-01-01), the resident's plan of care including the care plan, and Kardex file. [s. 6. (1) (c)]

Issued on this 9th day of December, 2021

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

Original report signed by the inspector.