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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Aug 17, 2020	2020_838760_0015	014869-20	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 Scarborough
3830 Lawrence Avenue East SCARBOROUGH ON M1G 1R6

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

JACK SHI (760)

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): August 5, 6, 7, 2020.

Log #004059-20 related to a significant change in condition.

A Critical Incident Systems inspection #2020_838760_00016 was conducted concurrently with this Complaints inspection.

During the course of the inspection, the inspector reviewed records, interviewed staff and conducted observations.

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

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that Director was informed of an injury with an unknown cause that resulted in the hospitalization of resident #001 and a change in their condition.

The Ministry of Long-Term Care (MLTC) received a complaint related to an injury that resident #001 sustained and resulted in a significant change in their status.

According to Ontario Regulation 79/10 s. 107 (7), “significant change” means a major change in the resident’s health condition that, (a) will not resolve itself without further intervention, (b) impacts on more than one aspect of the resident’s health condition, and (c) requires an assessment by the interdisciplinary team or a revision to the resident’s plan of care.

A review of the home’s progress notes for resident #001 indicated that they sustained a fall, a period before they were hospitalized and sustained injuries as a result of that fall. Interventions were rendered by the home's staff.

After a period since their fall, PSW #105 informed RPN #101 about resident #001’s condition. Resident #001 appeared to have a change in their condition and was assessed by RPN #101. Further diagnostics were required and resident #001 was sent to the hospital for further assessment, as per the directions from DOC #103. Resident #001 was admitted afterwards and diagnosed with an identified health condition and received medical treatments from the hospital.

A review of the hospital admission history notes indicated that resident #001 sustained a fall before being transferred to the hospital.

An observation of resident #001 by Inspector #760 showed they had an identified intervention on them to assist with healing from the injuries they sustained when they were transferred to the hospital.

PSW #105 was interviewed and indicated resident #001 had a new identified medical condition that morning they worked, prior to their hospitalization. PSW #105 called for RPN #101 to assess resident #001 and PSW #105 learned after that resident #001 was hospitalized. PSW #105 agreed that resident #001 had a significant change in their status due to changes to their activities of daily living and an intervention that was used on the resident upon their return to the home, due their diagnosed condition.

An interview with RPN #101 confirmed the events that occurred, as reported by PSW #105, but could not identify the exact cause of what lead resident #001 to have a change in their status. RPN #101 confirmed though that resident #001 did not sustain a fall prior to their transfer to the hospital.

PT #102 was interviewed and indicated their involvement in resident #001's fall that occurred a period before they were hospitalized and also to assess resident #001 when PSW #105 and RPN #101 noticed a change in their condition, right before resident #001 was sent to the hospital. PT #102 agreed at the time of their interview with Inspector #760 that resident #001 had a significant change in their status due to diagnosed injury. After the interview, PT #102 approached the inspector with DOC #103 and stated that they no longer agreed with their previous statement that the resident sustained a significant change of condition.

DOC #103 was interviewed and stated that nothing was documented in what lead up to resident #001’s diagnosed injury but did confirm that they sustained a fall a period prior to being hospitalized with their injury. DOC #103 confirmed that resident #001 had a significant change in their condition, due to changes to their activities of daily living. DOC #103 also confirmed that the home did not inform the Director regarding the significant change in status with resident #001, after they were hospitalized with an injury.

The home failed to ensure that the Director was notified about resident #001’s significant change in status, due to an unknown incident that resulted in their hospitalization and a diagnosis of an injury. [s. 107. (3) 4.]

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 Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

Issued on this 18th day of August, 2020

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

Original report signed by the inspector.