Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Telephone: 905-546-8294
Facsimile: 905-546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
Hamilton ON L8P 4Y7

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 23, 2011	2011_146_2321_23Mar110018	Complaint H-00520

Licensee/Titulaire
Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, ON., L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée
Extendicare St Catharines, ON., 283 Pelham Road, St Catharines, ON.,L2S 1X7

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

Barbara Naykalyk-Hunt, #146

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection.

During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care, registered staff and the RAI coordinator.

During the course of the inspection, the inspector: reviewed the health file of an identified resident, the home's Falls Management Program and the Point of Care records (POC's).

The following Inspection Protocol was used during this inspection: Falls prevention and management

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(11)(b)

6(11) When a resident is reassessed and the plan of care reviewed and revised,
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

1. An identified resident had the plan of care specific to falls risk reviewed and revised in February 2010, August 2010, February 2011 and most recently in March 2011.
2. The identified resident had 4 documented falls between October 2010 and March 2011. The identified resident's 3rd fall, resulted in a fracture.
3. The strategies in the plan of care to reduce or prevent falls were ineffective. New or different approaches were not considered in the care plan revisions until after the resident's 4th fall.

WN #2: The Licensee has failed to comply with O. Reg. 79/10, s.36

36 Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Findings:

1. An identified resident's plan of care stated that the resident was non-weight bearing and was a total mechanical lift with 2 staff to be present for toileting.
On one occasion, the resident was transferred to the toilet via mechanical lift and left unattended. The resident fell and sustained injuries.

WN #3: The Licensee has failed to comply O. Reg. 79/10, s.8(1)(b)

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,
(b) is complied with.

Findings:

1. The Home's Fall policy (2002) states to observe and monitor a resident after a fall for 24 hours. There is no documentation/evidence to support that this monitoring occurred in 3 out of 4 falls of an identified resident.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. for B Mayberry-Hunt Revised for the purpose of publication - Sept 29, 2011
Title: Date:	**Date of Report:** (if different from date(s) of inspection).