



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

**Rapport d'inspection  
prévues 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

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**Ministère de la Santé et des Soins de  
longue durée**

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<input type="checkbox"/> Licensee Copy/Copie du Titulaire		<input checked="" type="checkbox"/> Public Copy/Copie Public
<b>Date(s) of inspection/Date de l'inspection</b> March 23, 2011	<b>Inspection No/ d'inspection</b> 2011_146_2321_23Mar110018	<b>Type of Inspection/Genre d'inspection</b> Complaint H-00520
<b>Licensee/Titulaire</b> Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, ON., L3R 9W2		
<b>Long-Term Care Home/Foyer de soins de longue durée</b> Extendicare St Catharines, ON., 283 Pelham Road, St Catharines, ON., L2S 1X7		
<b>Name of Inspector(s)/Nom de l'inspecteur(s)</b> Barbara Naykalyk-Hunt, #146		
<b>Inspection Summary/Sommaire d'inspection</b>		
<p>The purpose of this inspection was to conduct a complaint inspection.</p> <p>During the course of the inspection, the inspector spoke with: the Administrator, the Director of Care, registered staff and the RAI coordinator.</p> <p>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).</p> <p>The following Inspection Protocol was used during this inspection: Falls prevention and management</p> <p><input checked="" type="checkbox"/> Findings of Non-Compliance were found during this inspection. The following action was taken: 3 WN</p>		

**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 la Loi de 2007 sur les foyers de soins de longue durée.

Non-respect avec les exigences sur la *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans la 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 3<sup>rd</sup> 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 4<sup>th</sup> 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:**

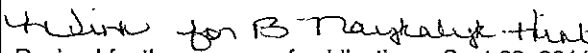
1. An identified resident's plan of care stated that the resident was non-weight bearing and was a total mechanical lift with 2 staff to be present for toileting.  
On one occasion, the resident was transferred to the toilet via mechanical lift and left unattended. The resident fell and sustained injuries.

**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.

<b>Signature of Licensee or Representative of Licensee</b> <b>Signature du Titulaire du représentant désigné</b>		<b>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.</b>
<b>Title:</b>		 Revised for the purpose of publication - Sept 29, 2011 <b>Date of Report:</b> (if different from date(s) of inspection).
<b>Date:</b>		