Ontario

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

Rapport d'inspection prevue 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

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Date(s) of Inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'insptection
October 15, 2010	2010_192_2321_15Oct092854	Critical Incident – H - 01635

Licensee/Titulaire
Extendicare Southwestern Ontario Inc.
(a subsidiary of 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
283 Pelham Road
St. Catherines, ON, L2S 1X7

Name of Inspector(s)/Nom de l'inspecteur(s)
Barbara Naykalyk-Hunt, Debora Saville

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspectors spoke with: the Administrator, and the Director of Care.

During the course of the inspection, the inspectors: Reviewed the resident's health record, draft policies on Hypoglycemia, Hyperglycemia, sliding scale insulin and diabetes management.

The following Inspection Protocols were used during this inspection:

Fall Prevention Inspection Protocol
Critical Incident Response Inspection Protocol

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

2 WN
1 VPN

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
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'ecrit de l'exigences prevue le paragraph 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 prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **LTCH Act, 2007, S.O. 2007, c.8 s6(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,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. A review of the Care Plan, for an identified resident, indicated disorders of the endocrine system-hypoglycemia, hyperglycemia with no direction to staff in the event of an hypo/hyperglycemia episode. The identified resident experienced a hypoglycemic episode and required treatment.

2. The identified resident was assessed as "high" falls risk, the care plan interventions do not provide clear direction to staff in the prevention of falls for an identified resident. The resident sustained a fall with injury.

Inspector ID #: #192, #146

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 interventions/strategies on each plan of care provide clear direction to staff.
This plan to be implemented voluntarily.

WN #2: The Licensee has failed to comply with **O. Reg. 79/10, s. 107(3)4**

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): An injury in respect of which a person is taken to hospital.

Findings:

An interview conducted with the Administrator, and Director of Care, confirmed that an incident involving a resident who was taken to hospital did not get reported to the Ministry of Health within one business day. The Critical Incident Report was not received by the Ministry of Health within one business day.

Inspector ID #:	#192, #146

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.** Debora Saville January 12, 2011
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection).