Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2017	2017_663682_0007	010148-17, 010149-17, 010151-17	Follow up

Licensee/Titulaire de permis

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. Catharines ON L2S 1X7

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

AILEEN GRABA (682)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 29, 30, 31, September 7, 2017

During the course of the inspection, the inspector reviewed documentation related to restraints, responsive behaviors, lifts and transfers and relevant clinical records, reviewed relevant policies, procedures, and practices within the home, reviewed education attendance records, safe transfer audits of direct care staff and observed the provision of care.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Director of Care (DOC), Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Resident Assessment Instrument (RAI) Co-ordinator and with residents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Minimizing of Restraining
Personal Support Services
Training and Orientation

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #003	2017_551526_0007	682
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2017_551526_0007	682
LTCHA, 2007 S.O. 2007, c.8 s. 76. (7)	CO #002	2017_551526_0007	682

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	Legendé 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 failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. A clinical record review for resident #001 indicated that the current plan of care on a identified date in 2017, indicated the resident's transfer status was assessed and revised to extensive assistance to be provided by two staff. The current plan of care also identified resident's #001 transfer status as limited assistance by one staff member. Observations of resident transfers on an identified date, confirmed that the resident was receiving extensive assistance with two staff. A transfer logo observed on the closet door in resident's #001 room on an identified date in 2017, indicated resident's transfer status was extensive assistance with two staff. On an identified date in 2017, staff #100 confirmed that resident #001 was an extensive assistance with two staff at all times. Staff confirmed that the resident was an extensive assistance with two staff and the intervention for limited assistance was not updated and removed from the written plan of care. Staff acknowledged that the home failed to ensure that the written plan of care for resident #001 set out clear directions to staff and others who provided direct care to resident #001.

B. A clinical record review for resident #002 indicated that on a identified date in 2017, the resident's transfer status was assessed and revised to include a total lift. A transfer logo observed on the closet door in resident's #002 room on a identified date in 2017 indicated resident's transfer status was a sit to stand lift. On a identified date in 2017, observations of resident #002 confirmed staff used a total lift with sling for transfer. On a identified date in 2017, staff confirmed that resident #002 was a total lift now since an identified date in 2017. An interview on a identified date in 2017, with staff confirmed that the transfer logo was incorrect and should have been removed. Staff confirmed that the home failed to ensure that the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to resident #002. [s. 6. (1) (c)]

Issued on this 14th day of September, 2017

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

Original report signed by the inspector.