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, 2018	2018_563670_0020	004298-18, 005109-18	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 Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

DEBRA CHURCHER (670), CASSANDRA TAYLOR (725)

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): September 4, 5, 6, 7 and 10, 2018.

The following intakes were completed with this inspection:
Log# 004298-18 Info Line #55759-LO related to a complaint alleging improper admission refusal.
Log# 005109-18 Info Line #55986-LO related to a complaint alleging improper staffing levels.

During the course of the inspection, the inspector(s) spoke with the Director of Care, two Registered Nurses, four Registered Practical Nurses, four Personal Support Workers, one Staff Scheduler, families and residents.

Inspector(s) also observed dining and snack service, staff and resident interactions, provision of care, reviewed clinical records, home and CCAC documentation regarding admission refusal, reviewed relevant clinical records and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Admission and Discharge
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Complaint log #005109-18/IL-55986-LO identified concerns regarding care for resident #002 relating to staff shortage and the resident not receiving the necessary assistance at specific times.

During a telephone interview with complainant on a specific date, it was stated that when newer staff were covering they were not aware of resident #002's care needs.

On two specific date, resident #002 was observed during a specific activity. There were four staff members present assisting residents with specific activities. Resident #002 was observed as well as staff support provided to resident #002 was observed during this specific activity.

On a specific date, during a staff interview with PSW #105 who stated that resident #002 required a specific staff intervention.

On a specific date, during a staff interview with PSW #106 who stated that resident required a specific staff intervention.

On a specific date, during a staff interview with Registered Practical Nurse (RPN) #108 it was stated that if staff didn't know a resident they would look at the care plan for direction.

Review of resident #002's care plan stated that resident #002 required specific staff interventions during a specific activity.

On a specific date, during an interview with the Director of Care (DOC) #103. Inspector #725 asked if DOC #103 was familiar with resident #002. DOC #103 confirmed they were. DOC #103 was asked if resident #002 required a specific staff intervention during a specific activity. DOC #103 confirmed that resident #002 required a specific staff intervention during a specific activity. Inspector #725 reviewed resident's #002's care plan with DOC #103. DOC #103 confirmed the care plan did not meet the current needs of the resident.

The licensee has failed to ensure that the care plan met the current care needs of resident #002. [s. 6. (2)]

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 care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that an applicant's admission to the home was approved unless; a) the home lacked the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lacked the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances existed which were provided for in the regulations as being a ground for withholding approval.

On a specific date, a complaint log #004298-18/ IL-55759-LO was submitted to the Ministry of Health and Long-Term Care (MOHLTC) pertaining to applicant#001 and a bed refusal from Extendicare Tecumseh.

On a specific date, the complainant provided the MOHLTC with a letter outlining dates of concern. The complainant stated that on a specfic date, applicant #001 was assessed for Long-Term Care (LTC). Choice homes were provided to the Community Care Access Centre (CCAC) Coordinator. Extendicare Tecumseh was applicant#001's first choice.

Applicant #001 was admitted to their last choice of preferred homes on a specific date, with the expectation they would be accepted to Extendicare Tecumseh when a bed became available. It was stated that on a specific date, CCAC Coordinator #110 informed applicant #001's family that Extendicare Tecumseh has turned the applicant down due to a specific condition. CCAC Coordinator #110 informed the family an appeal could be done. Applicant #001's family filed the appeal. On a specific date, applicant #001's family was informed they were next on the waiting list for Extendicare Tecumseh. On a specific date, applicant #001's family stated that CCAC coordinator #110 called to inform that applicant #001 would not be accepted due to a specific condition.

The complainant stated that on a specific date, they went to the Local Integrated Health Network (LHIN) and met with CCAC Patient Service Manager #111 to inform them of their concerns. On a specific date, CCAC Patient Service Manager #111 informed applicant #001's family that Extendicare Tecumseh would not accept applicant and would continue the rejection process.

The complainant stated that on a specific date, they called Extendicare Tecumseh and requested a copy of the rejection letter as one was not sent with the initial date of rejection on a specific date. The complainant spoke with the Director of Care (DOC) #103 and made arrangements for the complainant to go to the home to pick up the rejection letter.

Review of the rejection letter dated for a specific date, addressed to the complainant written by the DOC #103 of Extendicare Tecumseh. "I am writing to inform you of the decision of Extendicare Tecumseh regarding applicant#001 for admission to our facility. After extensive review of their file we have decided to decline admission of applicant #001 to our home. As you are aware, applicant #001's application reflected concerns regarding a specific condition. At this time the lack of specific devices for residents with specific abilities makes it very unsafe for them in relationship to the other residents. In addition, our staffing ratio does not allow us the ability to provide the specific interventions that they would require in order to insure their and the other resident's safety."

On a specific date, during an interview with DOC #103 they confirmed providing the family with a rejection letter. When asked why the resident was declined DOC #103 stated they believed it was due to a specific condition but were unable to locate any file. Inspector #725 stated to DOC #103 on day one of the inspection it was noted that a resident was admitted with the same condition as resident #001 and posed the question to DOC #103 what was different between this resident and resident #001. DOC #103 stated that they did accept residents with this specific condition but it would have depended at the time of what was going on in the home.

On a specific date, Inspector #725 was supplied with a list of residents who had specific interventions in place related to the specific condition that resident #001 was declined admission for, by Registered Practical Nurse (RPN) #102, the list contained names of 20 residents that resided in the home. During an interview on a specific date, with DOC #103 Inspector #725 asked what was the maximum number of residents with this specific condition the home could accommodate. DOC #103 stated that there was not a specific number and that it would depend on what was going on in the home.

The licensee has failed to ensure that applicant #001's admission to the home was approved. [s. 44. (7)]

Issued on this 14th day of September, 2018

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

Original report signed by the inspector.