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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 6, 2019	2019_563670_0003	019560-17, 019974-17, 027354-17, 028629-17, 028868-17, 000335-18, 001196-18, 006713-18, 008603-18, 009400-18, 018473-18, 021558-18	Critical Incident System

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): January 30, 31, February 1 and 5, 2019.

The following intakes were inspected during this inspection:
Log# 028629-17 CIS# 2904-000017-17 related to a fall with injury.
Log# 027354-17 CIS# 2904-000015-17 related to a fall with injury.
Log# 021558-18 CIS# 2904-000023-18 related to a fall with injury.
Log# 018473-18 CIS# 2904-000019-18 related to a fall with injury.
Log# 019974-17 CIS# 2904-000011-17 related to responsive behaviors.
Log# 028868-17 CIS# 2904-000018-17 related to responsive behaviors.
Log# 001196-18 CIS# 2904-000004-18 related to responsive behaviors.
Log# 009400-18 CIS# 2904-000015-18 related to responsive behaviors.
Log# 006713-18 CIS# 2904-000012-18 related to responsive behaviors.
Log# 000335-18 CIS# 2904-000002-18 related to responsive behaviors.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, five Personal Support Workers, one Registered Nurse, two Registered Practical Nurses, one Activation Aide, one Behavior Supports Ontario Personal Support Worker and one Behavior Supports Ontario Registered Practical Nurse.

The Inspector(s) also observed the overall cleanliness and maintenance of the home, observed staff to resident interactions and provision of care, completed relevant clinical record reviews and completed relevant record reviews of home specific documentation.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **1 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	Légende 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care related to an incident resulting in injury. The home amended the CIS report to include a second, similar incident that did not result in an injury.

Review of resident #009's clinical record showed that resident #009 had two separate but similar incidents. The initial incident resulted in an injury and the second incident did not. Resident #009 was found to have a specific item in use at the time of the second incident.

Review of resident #009's plan of care, that was current at the time of the second incident, showed a specific preventative intervention that specifically directed staff not to use the specific item that was noted to be in use at the time of the second incident.

During an interview with DOC #100 they confirmed that at the time of the second incident staff had used a specific item for resident #009 and should not have.

The licensee has failed to ensure that the care set out in the plan of care for resident #009 was provided to the resident as specified in the plan. [s. 6. (7)]

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 is provided to the residents as specified in the plan, to be implemented voluntarily.

Issued on this 6th day of February, 2019

[redacted]

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

Original report signed by the inspector.