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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Mar 21, 2019	2019_791739_0008	002406-19	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

JULIE DALESSANDRO (739)

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): March 19 and 20, 2019

The following intake was completed as part of this Critical Incident System inspection:
Log #002406-19, CIS #2904-000003-19 related to improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with Personal Support Worker(s), Registered Practical Nurse(s), and the Director of Nursing.

During the course of this inspection, the inspector(s) also conducted record reviews and observations relevant to the inspection.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident immediately reported the suspicion and the information upon which it was based to the Director.

Critical Incident System (CIS) report # 2904-000003-19 was submitted to the Ministry of Health and Long-Term Care on a specific date with Critical Incident dated 10 days prior to the report . The CIS identified that resident #001 sustained an injury to part of their body and it was determined that the injury occurred during a transfer from one surface to another. The mandatory report category on the CIS was identified as, improper/incompetent treatment of a resident that resulted in harm or risk to a resident.

Record review of resident #001's progress notes in Point Click Care (PCC) from a specific date and time indicated that resident #001 was being transferred from one surface to another and when a certain action occurred it caused an injury to a specific part of the resident's body. Resident #001 was put back to bed and a specific treatment was applied by the wound nurse.

During an interview on a specific date with Director of Care (DOC) #103 they stated that the incident involving resident #001 occurred on a specific date. DOC #103 stated that they heard about the incident during a morning meeting a day later and at this time they immediately removed the primary PSW, PSW #104, from the schedule until an investigation was completed. DOC #103 stated that the investigation commenced on a specific date and PSW #104 was terminated on a later date.

During another interview on a specific date with DOC #103 they stated that this incident occurred due to improper care of resident #001 and should have been reported immediately to the Director.

DOC #103 acknowledged that this incident was not reported immediately.

The licensee had failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident immediately reported the incident to the Director. [s. 24. (1)]

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 a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Critical Incident System (CIS) report # 2904-000003-19 was submitted to the Ministry of Health and Long-Term Care on a specific date with Critical Incident dated 10 days prior to the report. The CIS identified that resident #001 sustained an injury to part of their body and it was determined that the injury occurred during a transfer from one surface to another.

Record review of resident #001's progress notes in Point Click Care (PCC) indicated that resident #001 was being transferred from one surface to another when a certain action occurred and caused an injury to a specific part of the resident's body. Resident #001 was put back to bed and a specific treatment was applied by the wound nurse.

Record review of resident #001's care plan in PCC stated that resident #001 required specific assistance with lifts and transfers.

During an interview on a specific date with Personal Support Worker (PSW) #101, PSW #101 reinforced the care set out in the plan of care related to lifts and transfers for resident #001.

During an interview with Director of Care (DOC) #103 on a specific date, they stated that the investigation of this incident determined that resident #001 was transferred improperly by PSW #104 and that was how the injury was sustained.

DOC #103 acknowledged that an improper transfer by PSW #104 led to the injury on resident #001's body.

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001. [s. 36.]

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 22nd day of March, 2019

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

Original report signed by the inspector.