Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 20, 2024

Inspection Number: 2024-1388-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Tecumseh, Tecumseh

Lead Inspector	**Inspector Digital Signature**
Debra Churcher (670)	Debra Churcher Digitally signed by Debra Churcher Date: 2024.03.04 07:48:25 -05'00'

Additional Inspector(s)
Cassandra Taylor (725)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 12, 13, 14, 15, 2024

The following intake(s) were inspected:

Intake: #00099131 CIS #2904-000106-23 related to an alleged improper transfer.
Intake: #00103379 CIS #2904-000126-23 related to a fall with injury.
Intake: #00108529 Complaint related to concerns of an injury of unknown origin and alleged failure to recognize and treat a change in condition.

The following intakes were completed in this inspection: Intake #00097751 CIS #2904-000102-23003451, Intake #00097956 CIS #2904-000103-23, Intake

#00099913 CIS #2904-000108-23, Intake #00101856 CIS #2904-000120-23 related to falls.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: PLAN OF CARE

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident's plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary:
During an interview with two Personal Support Workers (PSW's) they stated that the resident had previously used a specific type of equipment for transfer however due to a change in condition they required the use of a different type of equipment for "quite some time."

Review of the minimum data set (MDS) assessments showed that the resident required extensive assistance and two staff for transfers with the quarterly assessment completed on a specific date and had a significant change in condition assessment completed just over two months later, where they determined the resident required total assistance of two staff for transfers.

The resident's care plan showed a goal that stated the resident would maintain their ability to safely transfer with two staff and a sit to stand lift. Interventions showed that on a specific date, an intervention for extensive assistance with two staff and a sit to stand lift had been resolved on the same date, and had been replaced with an intervention of total assistance with a mechanical lift and hammock sling.

During an interview with the Administrator and an RPN they acknowledged that the resident had a change in their condition resulting in the need for a change from the sit to stand lift to a full mechanical lift and stated that the care plan should have been revised at the time of the change in condition.

Failure to update the resident's plan of care to reflect their care needs placed the resident at risk for receiving an improper transfer and potential injury.

Sources:
A resident's clinical record, interviews with two PSW's, the Administrator and an

RPN.

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WRITTEN NOTIFICATION: TRENSFERRING AND POSITIONING TECHNIQUES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40
Transferring and positioning techniques
s. 40. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary:
Review of the home's internal investigation notes related to an alleged improper transfer showed that a Personal Support Worker (PSW) admitted to transferring a resident, alone, with a mechanical lift.

The home's safe lifting and care program stated that two trained staff were required at all times when performing a mechanical lift.

During an interview with the Administrator they acknowledged that the PSW performed an unsafe transfer as they did not follow the home's policy requiring two staff for all mechanical lifts.

The PSW's failure to follow the home's policy requiring two staff for all mechanical

lifts placed the resident at risk for injury.

Sources:
The home's internal investigation notes, the home's safe lifting and care program and interview with the Administrator.

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