Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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
Jul 18, 2019	2019_794749_0016	004341-19, 007210-19, 008046-19, 012854-19	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 Timmins
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

AMY PAGE (749), SHELLEY MURPHY (684), TIFFANY BOUCHER (543)

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): July 8 to 12, 2019.

The following intakes were inspected upon during this Critical Incident Inspection:
-Two intakes related to resident to resident abuse;
-One intake related to visitor to resident abuse; and,
-One intake related to an incident which resulted in an injury.

A Complaint Inspection #2019_794749_0018 and a Follow Up Inspection #2019_794749_0017 were conducted concurrently with this Inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and Residents.

Inspector(s) also conducted daily tours of the resident care areas, observed the provision of care towards residents, reviewed relevant licensee policies, procedures, programs, internal investigation documents and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 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. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the specified intervention for resident #004 had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

A critical incident report was submitted to the Director on a specified day in 2019, related to an incident that occurred, which resulted in an injury.

Inspector #543 reviewed resident #004’s most recent care plan, implemented at the time of the inspection. The care plan indicated that the resident had a specified intervention. The resident would use a specified mobility aid throughout the day, and the specified intervention would also be used for comfort and safety.

Inspector #543 observed resident #004 for a specified time frame during the inspection, and on six separate occasions the resident was observed using their specified mobility aid.

Inspector #543 reviewed the home’s specified intervention policy, last revised in February 2017. The policy indicated that consent was required from the resident, where possible, or the POA/SDM.

Inspector #543 interviewed RN #105, who verified that the specified mobility aid was a specified intervention. The RN indicated that they did not obtain consent for the use of the specified mobility aid.

Inspector #543 interviewed the DOC #109, who indicated that the purpose of initiating the specified mobility aid was as a specified intervention. The DOC verified that resident #004 was their own Substitute Decision Maker (SDM), and that consent was not obtained.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a specified intervention for a resident was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following were documented: 6. All assessment, reassessment and monitoring, including the resident's response.

A critical incident report was submitted to the Director on a specified day in 2019, related to an incident that occurred, which resulted in an injury.

Inspector #543 reviewed resident #004's most recent care plan, implemented at the time of the inspection. The care plan indicated that the resident had a specified intervention. The resident would use the specified mobility aid throughout the day, the specified intervention would also be used for comfort and safety.

Inspector #543 observed resident #004 for a specific time frame during the inspection, and on six separate occasions the resident was observed using their specified mobility aid.

Inspector #543 reviewed the home's specified intervention policies, last revised in February 2017. The policies indicated that at a minimum, the resident's response to the specified intervention and the need for the continued use of the specified intervention must be evaluated each shift and documented either on the specified intervention record, or where e-documentation was done.

Inspector #543 interviewed PSW #103, who indicated that resident #004 had been using the specified mobility aid for about a year, and that the specified mobility aid was a specified intervention. The PSW verified that the resident should be checked on hourly; and repositioned at a minimum every two hours. They indicated that they would

document the monitoring in Point of Care.

Inspector #543 interviewed RPN #104, who verified that resident 004’s specified mobility aid was a specified intervention. The RPN verified that they had not documented on the use of the specified intervention, and that is was not included in the Medication Administration Record (MAR) in the electronic MAR (e-MAR).

Inspector #543 interviewed RN #105, who verified that the specified mobility aid was a specified intervention. The RN indicated that the registered nursing staff should have been documenting every shift for the use of the specified intervention, and that it should have been identified in the resident’s MAR.

Inspector #543 interviewed the DOC #109, who indicated that the purpose of initiating the specified mobility aid was as a specified intervention. The DOC verified that the Registered staff were required to document every shift on the specified intervention; and confirmed that they were aware that this has not been done for resident #004's specified mobility aid.

Issued on this 18th day of July, 2019

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

Original report signed by the inspector.