Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jan 29, 2021	2021_864627_0001	020687-20	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 Timmins
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

SYLVIE BYRNES (627)

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): January 19-21, 2021.

The following intake was inspected during this Complaint inspection:

- One intake which was related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Support Service Manager, Infection Prevention and Control (IPAC) lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 there was a written plan of care that set out the planned care for a resident, specific to a fall prevention intervention.

Inspector #627 observed a resident with a fall prevention intervention in place.

The resident's current care plan did not identify the fall intervention.

The home's policy titled "Care Planning", indicated that "a care plan is a guide that directs care that is provided to the resident". A PSW stated that the care plan for the resident had not indicated the fall prevention intervention.

Sources: Inspector's observation, interviews with a PSW and DOC, resident's current care plan, Order Review Report and the home's policy titled "Care Planning". [s. 6. (1) (a)]

2. 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 resident's current care plan, for the focus of falls, indicated that the resident was to have a fall intervention in place for safety, while in the dining room. The Inspector observed the resident in the dining room without the safety intervention in place.

The DOC acknowledged that the resident should have had the intervention while in the dining room, for their safety.

Sources: Inspector observation, resident's current care plan, Order Review Report, home's policy titled "Care Planning", interview with a PSW, RPN and DOC.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the RPN complied with the home's fall prevention policy and procedures when a resident had a fall.

O. Reg. 79/10, section (s.) 48 (1) (1) requires that the home have written policies and procedures for the falls prevention and management program.

Specifically, the RPN did not comply with home's policy titled, "Falls Prevention and Management Program", which directed staff to "notify the [substitute decision maker (SDM)], as required" when a resident had a fall.

A resident's SDM was not made aware that the resident had a fall, until eight days after the fall occurred.

The RPN stated that they had not called the resident's SDM, to notify them of the resident's fall.

The DOC stated that when a resident fell during the night and was not injured, staff were to call the SDM the following day. The DOC acknowledged that the RPN had not called the resident's SDM to notify them of the fall.

Sources: Home's policy titled, "Falls Prevention and Management Program", interviews with complainant, RPN and DOC.

Issued on this 17th day of February, 2021

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

Original report signed by the inspector.