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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 26, 2015	2015_391603_0035	029575-15	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE TRI-TOWN
143 BRUCE STREET P.O. BOX 999 HAILEYBURY ON P0J 1K0

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

SYLVIE LAVICTOIRE (603), MARIE LAFRAMBOISE (628), SARAH CHARETTE (612)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 16-19, 2015

During the course of the inspection, the inspector (s) reviewed residents' health care records, reviewed various policies, procedures and programs, conducted a daily walk-through of the home, observed the delivery of resident care, staff to resident interactions, and observed medication administration and dining services.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Maintenance Manager, RAI-Coordinator, Activity Lead, Activity Aide, Laundry Lead, Registered Staff (RNs and RPNs), Personal Support Workers, Housekeeping Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide care to resident #011.

On November 19, 2015, Inspector #603 reviewed the resident's health care record which indicated that the resident had a pressure ulcer. Inspector reviewed the TAR and physician orders which indicated to check the area daily and change dressing every 5 to 7 days.

Inspector reviewed resident #011's care plan which had no focus or intervention for the pressure ulcer. Inspector interviewed S#103 who explained that the staff access the resident's care plan in order to know what care is required. Inspector interviewed S#100 who explained that a focus for a pressure ulcer and dressing change should have been identified in resident #011's care plan but was forgotten. [s. 6. (1) (c)]

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 ensuring that the plan of care sets out clear directions to staff and others who provide care to resident #011, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On November 17, 2015, Inspector #603 observed seven different residents' rooms. Some of the rooms were very dusty, floors and windows were soiled, and some of the residents' equipment were very unclean.

On November 18, 2015 at 1015hrs, Inspector #603 interviewed S#100 who explained that the home had established a weekly dusting of the residents' rooms, in addition to the daily cleaning. A deep cleaning of the residents' rooms is done 4 times a year and this includes the cleaning of the residents' wheelchairs and walkers. On November 8, 2015, staff members were brought in to do the cleaning of all wheelchairs and walkers.

On November 18, 2015, Inspector #603 and S#100 walked to two different residents' rooms and noted resident's equipment to be unclean and covered with debris and dusty furniture. Staff #100 confirmed these findings. [s. 15. (2) (a)]

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 ensuring that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM and any other person specified by the resident was notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

Inspector reviewed a Critical Incident Report (CI) which alleged staff to resident abuse by S#112 to three different residents. The incident occurred on a certain date and was reported to the Director on the same day. Inspector noted that the report indicated that the three residents' substitute decision makers (SDMs) were not notified of the alleged incidents.

Inspector interviewed S#100 who confirmed that the three residents' SDMs were not notified of the alleged incidents of abuse of the residents. [s. 97. (1) (b)]

2. The licensee has failed to ensure that the resident and the resident's SDM was notified of the results of the alleged abuse or neglect investigations immediately upon the completion.

Inspector reviewed a Critical Incident Report (CI) which alleged staff to resident abuse by S#112 to three different residents. The incident occurred on a certain date and was reported to the Director the same day. Inspector noted that the report indicated that the three residents' substitute decision makers (SDMs) were not notified of the alleged incidents.

Inspector interviewed S#100 who confirmed that the three residents' SDMs were not notified of the alleged incidents or the outcome of the investigations. [s. 97. (2)]

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.