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
Oct 15, 2021	2021_864627_0023	009493-21	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 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 BYRNES (627)

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): October 4-8, 2021.

The following intake was inspected during this Critical Incident System (CIS) inspection:

- One log related to a fall of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers and residents.

The Inspector conducted daily observations of the provision of care to the residents, staff to resident interactions, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control

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

Findings/Faits saillants :

The licensee has failed to ensure that the written plan of care for a resident set out their planned care.

A resident sustained a fall, while completing an activity of daily living (ADL), which caused a significant change to their health status. Upon review of the resident's written plan of care, the Inspector was unable to determine any focus or interventions for the resident's ADL. A Personal Support Worker (PSW) identified that staff referenced the resident's care plan and Kardex to know what care needs a resident had. The Assistant Director of Care (ADOC) identified that the resident written plan of care had not included a focus or intervention for the resident's ADL.

The lack of a focus for the ADL in the resident's care plan caused actual harm to the resident.

Sources: A resident's care plan; a Critical Incident System (CIS) report, home's policy titled, "Plan of Care"; interviews with ADOC and other staff. [s. 6. (1) (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 to ensure that there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

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 :

The licensee has failed to ensure that a Registered Practical Nurse (RPN) complied with the home’s policy and procedures when a resident fell.

O. Reg. 79/10, 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 transfer the resident post-fall using a mechanical lift, unless the resident was able to get up on their own.

A resident sustained a fall which resulted in a significant change to their health status. The RPN had not utilized a mechanical lift and two staff members when transferring the resident post fall. The ADOC identified that the home had a no lift policy and the resident should have been transferred with a mechanical lift and two staff members.

There was actual risk to residents for the lack of the implementation of the home's fall prevention and management program.

Sources: A resident's care plan; a Critical Incident System (CIS) report, home's policy titled, "Falls Prevention and Management Program"; interviews with ADOC and other staff members. [s. 8. (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 where the 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the Infection Prevention and Control (IPAC) program, related to hand hygiene.

The licensee's IPAC program required staff to ensure that residents were encouraged and assisted to wash their hands before, after meals and snacks. During three meal observations, the Inspector observed that residents were not assisted with performing hand hygiene prior to being served their meal or after their meal. When asked if residents were assisted with performing hand hygiene before and after meal services, a staff member replied that the residents' hands were washed during morning care, at bedtime care and anytime the residents' hands were visibly soiled. The Director of Care (DOC) indicated that the residents had been assisted with hand washing during a Covid outbreak, however, this was not continued after the outbreak.

There was actual risk to residents for the lack of the implementation of the home's hand hygiene program.

Sources: Inspector's observations of three meal services; Ontario's Just Clean Your Hands Implementation Guide and the home's policy titled, "Hand Hygiene"; Interviews with the DOC and other staff.

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 all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 15th day of October, 2021

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

Original report signed by the inspector.