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

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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 30, 2019	2019_509613_0022	012910-19, 012915-19	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 Van Daele
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

LISA MOORE (613)

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): July 24 - 26, 2019.

The following complaints were inspected during this inspection:

Two Complaints that were submitted to the Director regarding a fall resulting with an injury and late reporting to the substitute decision-maker.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Acting Director of Care (Acting DOC), Physiotherapist, Kinesiologist, Physiotherapy Assistant, Registered Nurses (RNs), Personal Support Workers (PSWs) residents and family members.

The Inspector also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigation files, and the licensee's fall prevention and management program, polices and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of resident #001's plan of care.

Two complaints were submitted to the Director, indicating that the substitute decision-maker (SDM) was not informed by the home that resident #001 had a fall resulting in an injury, until two days after the fall had occurred.

Inspector #613 reviewed resident #001's health care record. A review of the progress notes identified that resident #001 had a fall on a specific date and time and no injuries were noted. An entry on the same date, but at a later time documented by RN #107, identified that resident #001 was noted to have three areas of visible injury to their body and that they were experiencing discomfort. The progress notes described that resident #001's substitute decision-maker was not notified of the fall until two days after the fall had occurred.

A review of the licensee's policy titled, "Falls Prevention and Management Program" (RC-15-01-01) last revised on February 2017, instructed staff that for a post fall management intervention, that a member of the interdisciplinary team would notify the SDM of the fall and update the SDM with the resident's status changes and update the interdisciplinary care plan in collaboration with the family/SDM.

During interviews with RNs #102 and #104, they stated that any residents' SDMs were to be notified of all falls when they occurred; however, during a specific shift if there was minimal or no injury, the nurse would report to the on-coming shift nurse and write in the home's "Communication/24 Hour Report Book" for the nurse to contact the SDM and notify about the fall. RN #102 stated they had worked the shift following resident #001's fall, but had assumed that RN #107, who had worked the previous shift when the fall occurred, had notified the SDM of the fall, as they had not written in the "Communication/24 Hour Report Book".

A review of the "Communication/24 Hour Report Book" did not have any documentation regarding resident #001's fall on a specific date.

During interviews with the Administrator and the Acting Director of Care, they confirmed that resident #001's SDM had not been informed of the fall until two days after it occurred. They both stated it was the expectation for registered staff to notify the SDM

as soon as possible after a resident fell and this should have been completed by RN #102, regardless if it was not written in the "Communication/24 Hour Report Book". [s. 6. (5)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker is given an opportunity to participate fully in the development and implementation of resident #001's plan of care, to be implemented voluntarily.

Issued on this 30th day of July, 2019

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

Original report signed by the inspector.