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 28, 2020	2020_822613_0021	014668-20, 016479-20	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 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 Critical Incident System inspection.

This inspection was conducted on the following date(s): October 13-15 and 19-21, 2020.

The following intakes were inspected during this Inspection:

One Critical Incident (CI) report that was submitted to the Director regarding a resident fall resulting with an injury;

One CI report that was submitted to the Director regarding a resident to resident altercation.

A concurrent Complaint Inspection #2020_822613_0020 and a Follow Up Inspection #2020_822613_0022 were also conducted during this inspection.

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

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 reviewed various licensee's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Responsive Behaviours

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 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 where the Act or this Regulation required the licensee of a long-term care home to have institute, or otherwise put in place any system, the system was complied with.

In accordance with O. Reg. 79/10 s. 49., the licensee was required to ensure that a falls risk assessment was completed as per the home’s falls prevention and management program.

Specifically, staff did not comply with the licensee’s policy regarding “Falls Prevention and Management Program", which identified that post fall, the nurse would ensure a comprehensive assessment was undertaken and completed. The nurse would complete an initial physical and neurological assessment and determine if the resident could be safely monitored and treated within the home or if transfer to acute care was required.

A resident had a fall that resulted in an injury and transfer to the hospital. The progress notes indicated that the resident had complained of pain and had decreased movement to a specific part of their body and that a nurse proceeded to direct staff to assist the resident with a specific type of transfer from the floor to their bed.

The Assistant Director Of Care (ADOC), who was the Falls Program Lead, confirmed that the nurse had not followed the licensee's policy and should not have moved the resident from the floor when they had pain and decreased movement to a specific part of their body .

Sources: CI report, Falls Prevention and Management Program, resident's progress notes and interviews with nurse and ADOC.

2. In accordance with O. Reg. 79/10 s. 49., the licensee was required to ensure that a comprehensive assessment was undertaken post fall as per the home's falls prevention and management program.

Specifically, staff did not comply with the licensee's policy regarding "Falls Prevention and Management Program" (RC-15-01-01), which identified that the Nurse would screen all residents on admission or with a change in condition that could potentially increase the resident's risk of falls/fall with injury. (Fall Risk Assessment).

A resident had a fall that resulted in an injury and transfer to the hospital. A review of the resident's progress notes identified that this was the resident's third fall since their admission. A review of the resident's assessments on Point Click Care (PCC) identified that resident had not received a falls risk assessment since their admission.

The ADOC confirmed that staff had not followed the licensee's falls prevention and management program and that staff should have completed a falls risk assessment on the resident.

Sources: CI report, Falls Prevention and Management Program, resident's progress notes and interviews with nurse and ADOC. [s. 8. (1) (a),s. 8. (1) (b)]

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 Act or this Regulation required the licensee of a long-term care home to have institute, or otherwise put in place any system, the system was complied with. Specifically the licensee's falls prevention and management program, to be implemented voluntarily.

Issued on this 29th day of October, 2020

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

Original report signed by the inspector.