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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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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_0020	015091-20, 016417-20	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 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): October 13-16 and 19-21, 2020.

The following complaints were inspected during this inspection:

One Complaint that was submitted to the Director regarding the substitute decision-maker (SDM) not being notified of changes to resident care;

One Complaint that was submitted to the Director regarding multiple concerns of the provisions of care.

A concurrent Critical Incident System Inspection #2020_822613_0021 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 Administrator (ADM), Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and family members.

The Inspector(s) 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, and reviewed various licensee's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
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 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 was given an opportunity to participate to the extent possible in the development and implementation of a resident's care plan and in reviews and revision of the care plan.

A resident's clinical records identified that three of their medications had been put on hold, as ordered by the Medical Director. The resident's substitute decision-maker (SDM) had not been notified.

A nurse acknowledged that when there was a change in a resident's medication direction that the SDM was to be notified, as soon as possible, and provide consent for the changes and then once the SDM was notified it was to be documented in the progress notes or on the physician order sheets.

The Assistant Director of Care (ADOC) confirmed that the resident's SDM had not been notified when the medications had been ordered to be on hold.

Sources: Medication Administration Records (MARs), Pandemic Record Review, resident's progress notes, interviews with SDM, registered nurses and ADOC and review of Power of Attorney-Personal Care policy.

2. A resident returned from the hospital, and that their mobility and transfer status had declined. It was determined by the Physiotherapist that the resident could be assisted with a specific type of transfer. The progress notes identified that a transfer care plan was in place and staff were aware of the resident's transfer status; however, the progress notes did not indicate that the SDM had been notified of the resident's transfer status change.

A nurse acknowledged that the SDM should have been notified when there was a change in a resident's transfer status.

The ADOC stated the resident's transfer status had changed following their hospitalization and that the SDM should have been notified by the registered staff.

Sources: Physiotherapy assessments, progress notes, interviews with registered nurses and Power of Attorney-Personal Care policy review. [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 to the extent possible in the development and implementation of the resident's care plan and in reviews and revision of the care plan, to be implemented voluntarily.

Issued on this 29th day of October, 2020

[redacted]

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

Original report signed by the inspector.