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
Nov 25, 2021	2021_822613_0027	015180-21	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), JENNIFER LAURICELLA (542)

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): November 15-19, 2021.

The following intake was inspected upon during this Inspection:

One intake related to concerns regarding the provision of care.

A Follow Up Inspection #2021_822613_0026 and a Critical Incident System Inspection #2021_822613_0028 were conducted concurrently with this inspection.

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

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, staff to resident interactions, infection prevention and control (IPAC) practices, reviewed health care records, and various licensee's policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
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	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 policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48. (1) 1., the licensee was required to ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

Specifically, staff did not comply with the licensee's Falls Prevention and Management Program policy for two resident falls.

One resident had a witnessed fall and another resident had an unwitnessed fall. A post falls assessment was completed for both residents, five days after they had fallen.

A RN did not initiate a head injury protocol for the resident who had an unwitnessed fall, did not complete post falls assessments, and did not notify the residents' SDMs or complete incident reports for the two resident's falls.

ADOC stated that staff were expected to complete a post falls assessment immediately following a resident's fall, initiate a head injury protocol for all unwitnessed falls and notify the resident's SDM.

Failure of the registered staff to complete a post falls assessment immediately put the resident at risk to the provision of appropriate treatment and lack of monitoring their health status.

Sources: Complainant, Two resident's progress notes and assessments; the licensee's Falls Prevention and Management Program; and interviews with ADOC and a RN. [s. 8. (1)]

2. In accordance with O. Reg. 79/10, s. 48. (1) 2., the licensee was required to ensure that a skin and wound care program to promote skin integrity, prevent the development of wound and pressure ulcers, and provide effective skin and wound care interventions.

Specifically, staff did not comply with the licensee's Skin and Wound Program: Wound Care Management policy for a resident.

Altered skin integrity with extensive swelling was noted on a resident and a RN did not complete a full assessment on the resident and did not notified the physician or the resident's SDM of the altered skin integrity.

A RN verified that they should have completed a head to toe assessment and a risk management assessment and notified the physician and the resident's SDM.

ADOC stated that staff were expected to promptly assess a resident's altered skin integrity and complete the appropriate assessment tool, and notify the physician and the resident's SDM.

Failure of the registered staff to complete a skin assessment and implement immediate treatment put the resident at risk of worsening altered skin integrity.

Sources: Complainant, A resident's progress notes and assessments; the licensee's Wound Care Management policy and interviews with ADOC and a RN. [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 Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with, specifically, the Falls Management and Prevention Program and Skin and Wound Program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was to receive medication at a specific time; however, on a specific date, they received an extra dose of the medication at a different time.

A RPN verified that they had administered an extra dose of the medication to a resident.

Failure of registered staff administering medications in accordance with the directions specified by the prescriber put the resident at risk of adverse effects to their health status.

Sources: A resident's Electronic Medication Administration Record; The Shift Change Monitored Medication Count Record; and an interview with a RPN. [s. 131. (2)]

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 drugs are administered to resident #006 in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

See WN # 2 for specific details.

The ADOC confirmed there no documentation for the medication error that occurred on a specific date, involving a resident.

Sources: A resident's EMAR; Medication Incident Reports; and a interview with ADOC. [s. 135. (1)]

Issued on this 25th day of November, 2021

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

Original report signed by the inspector.