



**Ministry of Health and
Long-Term Care**
**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**
**Rapport d'inspection
prévues le Loi de 2007 les
foyers de soins de longue**

Health System Accountability and Performance
Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la
performance du système de santé
Direction de l'amélioration de la performance et de la
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|-----------------------------------|---------------------------------------|
| Sep 14, 19, 20, 2011 | 2011_074173_0005 | Complaint |

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE MISSISSAUGA
855 JOHN WATT BOULEVARD, MISSISSAUGA, ON, L5W-1G2

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

LESA WULFF (173)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the Inspector(s) spoke with Assistant Director of Care, Registered Staff, Personal Support Workers, Residents and Families

During the course of the inspection, the Inspector(s) Observed resident care, reviewed policy and procedure, reviewed clinical health records for Log # H001088-11

The following Inspection Protocols were used during this inspection:

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|------------------------------------|---------------------------------------|
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | WAO – Ordres : travaux et activités |



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| | |
|--|---|
| <p>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.)</p> | <p>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.</p> |
| <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

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 subsections:

- s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
 - (a) a goal in the plan is met;
 - (b) the resident's care needs change or care set out in the plan is no longer necessary; or
 - (c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has not ensured that a resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective. [LTCHA 2007, S.O. 2007 c.8, s.6(10)c]

a) An identified resident was assessed for leaning in the wheelchair in 2011. The OT (Occupational Therapist) and staff from Shoppers Health Care, the vendor for the wheelchair, worked together to make changes in an effort to correct the problem of the resident leaning. Family for the resident have since complained that the resident is still leaning in the wheelchair. During an interview with a registered staff member, she stated that she was aware that the resident was still leaning to one side in the wheelchair and that the problem had not been corrected. When asked if anyone had called the OT or Shoppers Health Care to reassess the resident in relation to this ongoing concern, she stated that no one had initiated a reassessment that she was aware of. There was no evidence of a referral to the OT or Shoppers Health Care found in the clinical record. Staff did not reassess the resident, review and revise the plan of care when the care set out in the plan has not been effective.

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 in relation to ensuring that a resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan has not been effective., to be implemented voluntarily.

Issued on this 20th day of September, 2011



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

Lesa Wulff