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
Jun 22, 2021	2021_861194_0004	006096-21	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 Oshawa
82 Park Road North Oshawa ON L1J 4L1

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

CHANTAL LAFRENIERE (194)

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): May 17, 18, 19, 20, 25, 26, 27 and 28, 2021

During this inspection a complaint related to allegations of staff to resident abuse was completed.

During the course of the inspection, the inspector(s) spoke with Assistant Administrator (AA), Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

Review of the identified resident's clinical health record, observation of the resident and of staff to resident provision of care.

The following Inspection Protocols were used during this inspection:
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plans of care for two residents, set out planned care for pain for the residents.

A resident was observed to be symptomatic but denied pain. The Medication Administration Record (MAR) for the resident, confirmed the resident received routine pain medication. The pain medication was increased during the observed month. The resident received several doses of the as needed pain medication during the reviewed period. The plan of care for the resident indicated that pain medication was to be given for specific skin condition but there was no evidence of a treatment in the observed month. An RN confirmed the resident was on pain medication. Two RPN's confirmed that staff were to complete the pain assessments and have a pain focus initiated in the care plan.

A Resident was not interviewable but was observed during the inspection period, at various times, to be uncomfortable while sitting in their wheelchair. Different PSW staff were observed approaching the resident, offering reassurance or distractions which were effective at the time of interaction. The resident received routine pain medication. The resident was provided several doses of as needed pain medication during the reviewed period. There was no indication of pain identified in the resident’s care plan. Two RPN's confirmed that staff were to complete the pain assessments and have a pain focus initiated in the care plan. A PSW indicated that one specific intervention, was effective for a short period of time for the resident. Another PSW stated that they were not sure if the resident was in pain, as the resident was unable to speak, and interventions were not effective. Failing to have planned care related to pain, set out in the resident’s plan of

care, increased the resident's risk of unmanaged pain.

Sources: Medications Administration Record (MAR), plan of care and pain assessments of twp residents, Treatment Administration Record (TAR) of a resident and interview of staff. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan, related to obtaining a specific treatment

The physician ordered a specific treatment for a resident. At various times, the resident was observed by the Inspector, to be uncomfortable. An RPN stated the resident had a physician's order for increased pain medication but they were waiting on the results of a specific treatment. The RPN confirmed that the home had missed the specific treatment order. The specific treatment was provided eleven days after being ordered. Failing to ensure that the care set out in the plan was provided to the resident, by completing specific treatment as ordered, may have resulted in the resident having unmanaged pain.

Sources: Observation of a resident, review of the physician's order and laboratory results and interview with staff. [s. 6. (7)]

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 ensuring that the written plan of care sets out planned care for resident with pain and ensures that the care set out in the plan of care is provided as specified, to be implemented voluntarily.

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Issued on this 23rd day of June, 2021

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

Original report signed by the inspector.