Ontario

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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 19, 2013	2013_216144_0049	L-000546-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE PORT STANLEY
4551 EAST ROAD, PORT STANLEY, ON, N5L-1J6

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

CAROLEE MILLINER (144)

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): July 25 and 26, 2013

[redacted]

During the course of the inspection, the inspector(s) spoke with one visitor, three residents, the Administrator/DOC, Resident Program Manager, Infection Control Nurse, two Registered Nurses, three Registered Practical Nurses, two Personal Service Workers and one Housekeeping Aide.

During the course of the inspection, the inspector(s) reviewed one resident health record, the home's infection control line list records, Hand Hygiene Policy and the Medical Director Agreement.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that every resident had the right to be cared for in a manner consistent with his or her needs. Staff interviews and review of the health record for one resident confirmed the following:

- The resident displayed signs and symptoms of illness. The nurse documented the resident needs follow-up by the doctor and wrote the resident's name on the doctors list.
- Family reported the nurse advised them the physician could not be called after 22:00 hours.
- Family requested medication be ordered by the physician. The nurse left a telephone message for the physician.
- Family requested the resident be transferred to hospital for assessment. A message was left for the physician & the call returned six hours later.
- Two staff confirmed there was an internal directive concerning the practice of not contacting the physician after 22:00 hours. [s. 3. (1) 4.]

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 related to every resident having the right to be cared for in a manner consistent with his or needs, to be implemented voluntarily.

WN #2: 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 :

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1. The licensee did not ensure the home's plan, policy, protocol, procedure, strategy or system related to hand hygiene is complied with.
- Two staff were observed, each on two occasions, exiting and entering resident rooms without washing their hands.
- Three staff confirmed the home Hand Hygiene Policy directs staff to wash their hands between personal contact and environmental exposure to residents. [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 related to ensuring the home's plan policy, protocol, strategy or system related to the Hand Hygiene Policy is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee did not ensure that one resident received individualized personal care, including hygiene care and grooming on a daily basis.
- Family reported to the nurse that the resident had not been properly groomed.
- Review of the resident daily flow sheet revealed staff did not sign the record on two occasions to confirm the care had been provided.
- Two staff confirmed the care was not provided to the resident. [s. 32.]

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 related to ensuring that each resident of the home receives individualized personal care, including hygiene care and grooming on a daily basis, to be implemented voluntarily.

Issued on this 19th day of August, 2013

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