Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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 27, 2019	2019_823653_0029	017264-19	Critical Incident System

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 Rouge Valley
551 Conlins Road TORONTO ON M1B 5S1

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

ROMELA VILLASPIR (653)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 13, 14, 15, 18, and 19, 2019.

Critical Incident System (CIS) Log #017264-19 related to a fall resulting in an injury, was inspected during this inspection.

During the course of the inspection, the inspector reviewed the staff schedule, clinical health records, hospital records, and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Investigating Coroner (IC), interim Director of Care (iDOC), and the interim Administrator.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with, and complemented each other.

The home submitted a Critical Incident Report (CIR) to the Director for an incident that caused an injury to resident #001 for which they were taken to hospital and which resulted in a significant change in their health status. The CIR indicated resident #001 was found on the floor in their bedroom, complained of discomfort, and was sent to hospital for further assessment.

A review of resident #001's hospital records indicated they had an identified acute medical condition.

A review of resident #001's written plan of care indicated they had potential for the recurrence of the acute medical condition, and interventions were in place.

A review of resident #001's progress notes for a period of 10 days, revealed they exhibited signs and symptoms of the identified acute medical condition prior to their fall and hospitalization. A review of the lab report confirmed resident #001 had the acute medical condition.

Separate interviews with RPNs #103, #105, and RN #101 acknowledged that resident #001 was at risk for the recurrence of the acute medical condition, and further indicated as soon as signs and symptoms of the acute medical condition were observed by the registered staff, the doctor should be notified.

An interview with the interim Administrator indicated resident #001 was capable to say if they were experiencing discomfort, and further indicated that once the registered staff noted the resident exhibiting the identified symptom of the acute medical condition, they should at least call the doctor.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #001 so that their assessments were integrated, consistent with, and complemented each other. Resident #001 had a known history of the recurrence of the acute medical condition, and there was no indication that the registered staff called the doctor upon being made aware of resident #001 exhibiting the identified symptom of the acute medical condition. Furthermore, there was no indication of nursing staff collaboration in obtaining resident #001's identified specimen, not until after resident #001's family member followed-up with the staff. [s. 6. (4) (a)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

Issued on this 27th day of November, 2019

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

Original report signed by the inspector.