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
Dec 22, 2020	2020_832604_0018	023542-20	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

SHIHANA RUMZI (604)

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): December 16, 17, 18, and 21, 2020.

During the inspection an intake related to fall with injury was inspected.

During the course of the inspection, the inspector(s) spoke with the Physiotherapist (PT)Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

During the course of the inspection the inspector reviewed resident health records, room observations related to resident fall interventions, Long-Term Care Home (LTCH). net for CIS amendments, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed the to ensure the plan of care set out clear directions to staff and others who provided direct care to the resident.

The home submitted a Critical Incident System (CIS) report which indicated the resident had sustained a fall, transferred to hospital for further assessment. The CIS report indicated the resident sustained multiple falls. A review of the resident's care plan indicated the needs and interventions did not provide clear direction to staff related to level of assistance required by the resident. In separate interviews the Physiotherapist (PT) and Registered Nurse (RN) reviewed the care plan and acknowledged the care plan did not provide clear direction to staff as to the resident's level of assistance needed for care.

Sources: Review of CIS report, residents care plan, and interview with PT and RN.

2. The licensee has failed to ensure the resident was being reassessed and the care plan was revised because the care set out in the plan had not been effective and different approaches were considered in the revision of the care plan.

The home submitted a CIS report which indicated the resident had sustained a fall, transferred to hospital for further assessment due to injuries. The CIS report indicated the resident sustained multiple falls and a review of the care plan's revealed interventions were not reviewed and revised related to the residents identified care need as the set interventions where not effective. In separate interviews the PT and RN reviewed the care plans and acknowledged when the care set out in the care plan was not effective and different approaches had not been considered in the revision of the care plans.

Sources: Review of CIS report, residents care plans, and interview with PT and RN.

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:
-the plan of care set out clear directions to staff and others who provided direct care to the resident
-the resident was being reassessed and the care plan was revised because the care set out in the plan had not been effective and different approaches where considered in the revision of the care plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure the written report included the outcome or current status of the individual or individuals who were involved in the incident.

The home submitted a CIS report indicating the resident had sustained a fall, was transferred to hospital for further assessment, and was provided care in hospital. In an interview with the Administrator they reviewed the LTCH CIS reporting site and acknowledged the CIS report was not updated to include the outcome of resident #001's post fall.

Sources: Review of CIS report, LTCH CIS reporting site, progress note documentation, and interview with Administrator.

Issued on this 22nd day of December, 2020

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

Original report signed by the inspector.