

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
Oct 4, 2019	2019_820130_0004	011125-19, 016557- 19, 016750-19	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 St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

GILLIAN HUNTER (130), AILEEN GRABA (682), KELLY CHUCKRY (611)

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): September 18, 19, 20, 23, 24, 25, 26, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed the provision of care and reviewed relevant resident clinical records.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Support Services Manager, registered staff, Personal Support Workers (PSW)s and family members.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Infection Prevention and Control

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

0 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

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NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<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>The following constitutes written notification of non-compliance under paragraph 1 of section 152 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>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 O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

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The licensee has failed to ensure that any actions taken with respect to residents #001, #010 and #009 under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A) The plan of care for resident #001 was reviewed and indicated the resident was to receive a specific care intervention on identified dates in 2019.

A review of the point of care (POC) look back report over a specified time period in 2019 showed that staff documented the specific care intervention eight out of nine times during the specified time period.

In an interview, PSW #122, confirmed that they were the primary care staff who provided care to the resident on the identified date in 2019; however, they ran out of time during their shift, to record the care in POC.

Staff #123 confirmed in an interview, that the specific care intervention for resident #001 was not documented as given, in POC as required.

B) The plan of care for resident #010 was reviewed and indicated the resident was to receive a specific care intervention on identified dates in 2019.

A review of the POC look back report over a specified time period in 2019 showed that staff documented the specific care intervention seven out of nine times during the specified time period.

In an interview, RN # 118, confirmed that they had not received a report from front line staff to indicate the resident had not received the specific care intervention on the identified dates. The resident's family member was interviewed and confirmed that they visit every day and that the resident had received their specific care intervention during the specified time period.

Staff #123 confirmed in an interview, that the specific care intervention for resident #010 was not documented in POC, as required.

C) The plan of care for resident #009 was reviewed and indicated the resident was to receive a specific care intervention on identified dates in 2019.

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A review of the POC look back report and interview with staff #123, confirmed that staff documented the specific care intervention seven out of eight times during the specified time period.

In an interview, PSW staff #124, confirmed that they were the primary care giver for the resident on a specified date in 2019 and that the resident did receive their specific care intervention; however, the intervention was not documented in POC.

Staff #123 confirmed in an interview, that the specific care intervention for resident #009 was not documented in POC as required, as required.

Issued on this 4th day of October, 2019

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

Original report signed by the inspector.