Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of inspection/Genre d'inspection
April 20, 2011	2011-190-2904-20Apr102719	L-000583 Complaint

Licensee/Titulaire

Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, Ontario L3R 9W2

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

Extendicare Tecumseh, 2475 St. Alphonse Street, Tecumseh, Ontario N8N 2X2

Name of Inspector/Nom de l'inspecteur

Sandra Fysh #190

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to care and services.

During the course of the inspection, the inspector spoke with the Administrator, Acting Director of Care, Registered Nurse, Registered Practical Nurse, Personal Support Workers, personal caregiver.

During the course of the inspection, the inspector viewed the clinical records of one resident, observed the lunch meal in the dining room and observed residents in their rooms.

The following Inspection Protocols were used in part or in whole during this inspection:

- Dining IP
- Dignity, Choice and Privacy IP
- Nutrition and Hydration IP
- Personal Support Services IP
- Skin and Wound IP

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN

Revised for Publication

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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.)	Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.3(1)(8) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
(8) Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

Findings:

1. On [redacted] a Registered Practical Nurse completed an accuchek reading on a resident in the dining room with three other residents at the table.
2. On [redacted], the Registered Practical Nurse also administered insulin to a resident at the dining room table with three other residents at the table.

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WN #2: The Licensee has failed to comply with LTCHA,2007,S.O.2007,c.8,s.6(1)(c) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident.

Findings:

1. Documentation on daily flowsheets and progress notes indicate that a resident has been refusing mouth care, but there are no clear directions for staff for interventions or successful methods of providing oral care for this resident.
2. There are no clear directions for staff to follow to ensure oral care if the resident is resistive to mouthcare.

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WN #3: The Licensee has failed to comply with O.Reg.79/10,s.50(2)(d) Every licensee of a long-term care home shall ensure that, **(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated.**
Findings: 1. A resident was observed initially at 1000 hrs on April 20, 2011 laying supine in bed with head of bed elevated approximately 45 degrees. This resident was subsequently observed at 1030 hrs, 1100 hrs, 1120 hrs, 1205 hrs and 1235 hrs in exactly the same position. The resident remained in this position until transfer to the hospital at 1300 hrs. 2. Resident has a Stage III pressure ulcer on his coccyx and is dependent on staff for repositioning.

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Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Sandra Taylor
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). Apr 28, 2011