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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 19, 2017	2017_532590_0012	019214-16, 029061-16, 008814-17	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE TECUMSEH
2475 ST. ALPHONSE STREET TECUMSEH ON N8N 2X2

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

ALICIA MARLATT (590)

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): June 5, 6, 7, 8 and 12, 2017.

The following Critical Incidents were inspected concurrently and were related to falls management and prevention:

LSAO Log #008814-17/CI #2904-000004-17
LSAO Log #029061-16/CI #2904-000017-16
LSAO Log #019214-16/CI #2904-000005-16

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), a Resident Assessment Instrument Coordinator, two Registered Nurses (RN), three Registered Practical Nurses (RPN), and two Personal Support Workers (PSW) and one Resident.

During the course of the inspection, the inspector(s) reviewed Critical Incident reports, resident's clinical records including incident reports and relevant policies related to inspection.

During the course of the inspection, the inspector(s) observed, resident's and their rooms for fall interventions, staff/resident interactions and infection control and prevention practices.

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided

to the resident as specified in the plan.

The home reported to the Director on a specific date, through Critical Incident System reporting, that a resident had fallen and was sent to the hospital for medical intervention. The CI stated that the management team completed follow up to the incident by interviewing staff working at that time, and staff shared that a safety device had not been applied at the time of the fall.

Review of this resident’s progress notes showed that the resident suffered a fall on a specified date, and was sent to the hospital for medical intervention, and returned to the long term care home the same day. The progress note documentation stated that the PSW could not recall applying the resident’s safety device and acknowledged that it was not fastened at the time of the fall.

Review of this resident's physician’s orders was completed. The review showed that a physician’s order was written on a specific date, for the resident to wear a safety device while up in their wheelchair.

Review of the “Follow Up Question Report”, showed that the safety device was not applied during times when the resident was up in their wheelchair.

Review of the completed post fall assessment, showed that the resident was not restrained at the time of the fall.

Review of this resident’s care plan showed that there were two different areas, falls and restraints, where the staff were directed to apply a safety device while the resident was up in their wheelchair.

Review of a restraint assessment dated prior to the fall, showed that the family had requested this resident wear the identified device for safety.

In an interview with a PSW, they shared that this resident wears a safety device at all times while up in their wheelchair. They shared the resident wears the safety device for positioning purposes and falls prevention.

In an interview with a RPN, they shared that this resident is supposed to wear a safety device while sitting in their wheelchair. The RPN also shared that the family had requested this intervention for safety purposes.

In an interview with the Administrator and the DOC, they stated that the safety device was included in the resident's plan of care and that the plan of care had not been followed. They shared that two staff members were disciplined related to this incident and education was provided to them. They acknowledged that moving forward, they have implemented new signage for the residents rooms, to indicate discreetly and quickly to staff who is to use a safety device. They hoped this would be helpful as most devices are applied to resident's while they are in their rooms.

The licensee failed to ensure that an identified resident's safety device was applied when they were in their wheelchair as outlined in their plan of care.

The severity was determined to be a level three as there was actual harm to the resident as a result. The scope of this issue was isolated. The home has a history of this legislation being issued on November 3, 2016, in a Complaint inspection #2016_531518_0051 as a Voluntary Plan of Correction (VPC). [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 20th day of July, 2017

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

Original report signed by the inspector.