Ontario

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 17, 2017	2017_532590_0011	002355-16, 030060-16, 030964-16, 031168-16, 033382-16, 033608-16	Complaint

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), SHERRI COOK (633)

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

The following complaints were inspected concurrently:

LSAO Log #030060-16/IL-47340-LO was related to responsive behaviours and prevention of abuse and neglect.
LSAO Log #030964-16/IL-47390-LO was related to food quality, staffing levels, dining services and resident care issues.
LSAO Log #002355-16/IL-42294-LO and IL-42295-LO was related to a resident's nutrition and hydration.
LSAO Log #033608-16/IL-48244-LO was related to responsive behaviours and prevention of abuse and neglect.
LSAO Log #033382-16/IL-48185-LO was related to reporting and complaints and medication management in the home.
LSAO Log #031168-16/IL-47633-LO was related to housekeeping and maintenance services.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Maintenance Supervisor, the Housekeeping Supervisor, the Dietary Manager, a Resident Assessment Instrument Coordinator, a Dietary Aide, a Housekeeper, three Registered Nurses (RN), five Registered Practical Nurses (RPN), eight Personal Support Workers (PSW) and six family members and residents.

During the course of the inspection, the inspector(s) observed staff/resident interactions, resident/resident interactions, dining services, housekeeping services, posting of required information, resident home areas, medication administration and infection control and prevention practices.

During the course of the inspection, the inspector(s) reviewed Infoline reports, resident's clinical records including risk management reports, staffing plans and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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)**

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.

A complaint was received by the Ministry of Health and Long Term Care that the home did not follow the physician's orders related to a resident's nutrition and hydration.

An identified resident returned to the home from a hospital admission with specific orders for this resident's nutritional regimen. The nutritional regimen had also been identified in the residents care plan at the time of the incident.

Review of this resident's progress notes showed that an entry was made on a specified date, that stated a staff member discovered that the nutritional regimen was not being followed. The note stated that the feeding was stopped immediately and the incident was reported to the charge nurse, the physician and the resident's Substitute Decision Maker (SDM).

Review of the Risk Management report completed by the home showed that the resident received an excess of nutrition rather than what was to be administered, on the identified date.

In an interview with the Administrator and the Director of Care (DOC), they both acknowledged that there was an error made resulting in the resident's nutritional regimen not being followed.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this non-compliance was isolated. The home has a history of this legislation being issued in the home on November 3, 2016, as a Voluntary Plan of Correction (VPC) in a Complaint inspection #2016_531518_0051. [s. 6. (7)]

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Issued on this 19th day of July, 2017

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

Original report signed by the inspector.