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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2017	2017_671684_0005	022198-17	Resident Quality Inspection

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 TRI-TOWN
143 BRUCE STREET P.O. BOX 999 HAILEYBURY ON P0J 1K0

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

SHELLEY MURPHY (684), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 16-19, 2017.

The Inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, home policies and procedures, mandatory training records, staff work routines, schedules and personal records, observed resident rooms and common areas, and observed the delivery of resident care and services, including resident-staff interactions.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Dietary Manager, Registered Practical Nurses (RPNs), Resident Assessment Instrument – Minimum Data Set Coordinator (RAI Coordinator), Personal Support Workers (PSWs), families and residents.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs changed or the care set out in the plan was no longer necessary.

Resident #007 was identified as using a device, from their most recent Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #007's care plan and identified that as per the physician order, the resident had a specified device. The Inspector reviewed the physician orders within Point Click Care (PCC) and identified an order created on a specified date, indicating that the resident was ordered a different device.

During an interview with Inspector #638, RPN #107 stated that resident #007 required a device and was using a specified device as per the Physicians orders. The Inspector reviewed the resident's care plan and Physician orders with the RPN who indicated that whenever a change was required in a resident's care plan the changes would be relayed to the Resident Assessment Instrument (RAI) Coordinator and they updated the resident's care plan. The RPN indicated that when there was a change in the resident's interventions, these changes may not have been relayed to the RAI Coordinator to ensure that the care plan was updated.

Inspector #638, interviewed the RAI Coordinator who indicated that whenever a resident's care needed changing the staff would relay these changes to the RAI Coordinator. Inspector #638 reviewed resident #007's Physician orders and care plan with the RAI Coordinator who indicated that the order for the device should have been included within the resident's care plan and may have been missed.

Inspector # 638 reviewed the home's policy titled "Care Planning and Assessments – RC-05-01-01" last revised April 2017, which indicated that the nurse and interdisciplinary team were to ensure that the care plan was revised when appropriate to reflect the resident's current needs.

During an interview with Inspector #638, the Administrator indicated that whenever a resident's care needs changed, this information was relayed to the RAI Coordinator who updated the resident's care plan accordingly. The Administrator indicated that the care plan should have been updated to show the resident's needs. [s. 6. (10) (b)]

2. During an interview with Inspector #638, RPN #101 stated that resident #003 had a device due to a specified diagnosis. Resident #003 was also identified as using a device, from their most recent MDS assessment.

Inspector #638 reviewed resident #003's care plan and identified a specified device to be used as per the Physician orders. The Inspector reviewed resident #003's Physician orders in PCC and identified a physician order created on a specified date for a specific device.

During an interview with Inspector #638, RPN #107 indicated that resident #003 previously had one type of device and had since been ordered a different device. They indicated that the resident never had one specified device ordered and that it must have been an error in transcribing.

During an interview with Inspector #638, the RAI Coordinator indicated that resident #003 had used a specified device and that the care plan had not portrayed the appropriate interventions and that it was most likely an oversight or transcribing error.

Inspector #638 interviewed the Administrator who indicated that whenever a resident's needs changed, staff ensured that the care plan was amended and portrayed the needs of the resident. The Administrator indicated that this was most likely a transcribing error as they do not use this specific device in the home and this would not have been ordered for resident #003. [s. 6. (10) (b)]

Issued on this 31st day of October, 2017

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

Original report signed by the inspector.