Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 10, 2021	2021_824736_0001	015743-20	Critical Incident System

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 Tri-Town
143 Bruce Street P.O. Box 999 Haileybury ON P0J 1K0

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

AMANDA BELANGER (736)

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): January 18-21, 2021.

During the course of the inspection, the following log was inspected:
-one intake related to a report that was submitted to the Director related to a resident fall that resulted in injury.

Please note: A Follow Up (FUP) inspection (#2021_824736_0002) was conducted concurrently with this Critical Incident (CI) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Office Manager, Screener, Registered Nurse (s)(RNs), Registered Practical Nurse(s)(RPNs), and Personal Support Worker(s) (PSWs).

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant resident charts, and licensee policies and procedures, as well as internal audits.

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

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
2 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	Légende 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).

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 care was provided to the resident as set out in their plan of care.

The resident's care plan indicated a specific intervention related to falls prevention. On one occasion, the resident sustained a fall. In an interview with a Registered Nurse (RN), they indicated that a staff member had been providing care to the resident, and did not have the specified intervention in place. The RN indicated that care was not provided to the resident as specified in their plan of care. The resident was noted to have sustained an injury after the fall.

Sources: The resident's progress notes and care plan; Critical Incident (CI) report; interview with a RN and other staff. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care was reviewed and revised any time the resident's care needs changed or the care set out in the plan was no longer necessary for two residents.

a) At the time of the inspection, a resident's care plan provided direction to staff related to lifts and transfers. The resident's Kardex provided a different direction to staff related to lifts and transfers. The resident's care plan also indicated to staff that the resident's last fall was on a specified date; the progress notes indicated that the resident sustained two further falls.

In an interview with a Personal Support Worker (PSW), they indicated to the Inspector

that the resident’s care plan was not current and did not provide correct information. In an interview with a Registered Practical Nurse (RPN), they indicated that during the course of the inspection, they had been in the process of updating the resident's plan of care, as it was not up to date, and that they had removed the date the resident had last fallen, as it was not current. The RPN also indicated that the resident’s plan of care should have been reviewed and revised as their care needs changed, and that it had not been.

Sources: The resident’s care plan, kardex and progress notes; interviews with a PSW, and a RPN, as well as other staff.

b) A second resident's care plan indicated that the resident was independent with activities of daily living (ADLs). The progress notes indicated that the resident had been requiring additional assistance for ADLs. The resident’s care plan also indicated that they last sustained a fall on a specified date, however, the resident had sustained a fall since that time.

In an interview with a PSW, and a RPN, they both indicated that the resident required specific staff assistance with ADLs. The RPN indicated that the resident’s plan of care should have been revised when the care needs changed.

Sources: The resident’s care plan, Kardex, and progress notes; Inspector observations; interviews with a PSW, a RPN and other staff. [s. 6. (10) (b)]

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, and ensure that when a resident's care needs change, the plan of care is reviewed and revised as needed, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a post-fall assessment, using a clinically appropriate assessment instrument that was specifically designed for falls, had been completed after two separate residents sustained falls.

a) A resident sustained two separate falls. The Inspector was unable to locate a post fall assessment for either fall. In an interview with the Administrator/DOC, they indicated that after a resident sustained a fall, a post fall assessment was to be completed through Point Click Care. The Administrator/DOC and Inspector reviewed the resident's chart, and was unable to locate a post fall assessment for the resident for either fall.

Sources: CI report; the resident's progress notes and assessments; licensee's policy titled "Falls Management" last updated December 2019, #RC-15-01-01; interviews with the Administrator/DOC, and other staff.

b) A second resident sustained a fall, and had a post fall assessment opened. The assessment was not completed, and was missing information.

In an interview with the Administrator/DOC, they indicated that resident had a post fall assessment opened, however, the assessment was not completed in its entirety and should have been.

Sources: The resident's post fall assessment; interviews with Administrator/DOC, and other staff; licensee policy titled "Falls Management", last updated December 2019, #RC-15-01-01. [s. 49. (2)]

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 when a resident has sustained a fall, a post fall assessment is completed, to be implemented voluntarily.

Issued on this 16th day of February, 2021

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

Original report signed by the inspector.