Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

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

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Nov 5, 7, 8, 9, 10, 23, Dec 12, 19, 2011	2011_057163_0022	Complaint

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO 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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), registered nursing staff, personal support workers (PSWs), registered dietitian (RD), residents and family members.

During the course of the inspection, the inspector(s) conducted a walk through of resident home areas and common areas, observed meal service, reviewed resident health care documentation, observed staff to resident interactions, and reviewed staffing plans.

The following Inspection Protocols were used during this inspection:

Personal Support Services

Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 8. Nursing and personal support services

Specifically failed to comply with the following subsections:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there is at least one registered nurse (RN) on duty and present at all times in the home. The inspector interviewed the Administrator/DOC on Nov 7/11 about RN staffing. It was reported "the home does not provide RN staffing 24/7 because of a lack of available RNs".
The inspector reviewed a copy of the RN staffing schedule from Sept 9/11 to Nov 3/11 with the Administrator/DOC. During this time period, there were a total of 40 shifts where an RN was not on duty and present in the home at all times.

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 there is at least one registered nurse (RN) on duty and present at all times in the home, to be implemented voluntarily.

WN #2: 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 subsections:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure the a substitute decision-maker was given an opportunity to participate fully in the development and implementation of a resident's plan of care. A "Pharmacy Communication Record" record dated July 06/11 indicated that a prescribed medication could not be provided to a resident due to a back order. According to a letter of complaint from a Power of Attorney (POA) to the home, they were not informed until July 21/11 that their family member would not be receiving the prescribed medication, but rather an alternative medication. The inspector interviewed the Administrator/DOC on Nov 7/11. It was confirmed that the POA should have been notified about the substitution of medications.
2. A response letter written by the home dated July 25/11 confirmed that the POA was not provided with an explanation of their family member's plan of care regarding a change in medication. The letter written by the Administrator/DOC reads "I apologize that you were not notified of the change at the time it had occurred".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee did not ensure that residents receive grooming on a daily basis. Fifteen residents were observed in the dining room at breakfast on Nov 8/11 that appeared not to be groomed with hair matted. The inspector interviewed a RPN on Nov 8/11 regarding resident grooming. It was reported "the plan is that staff are to ensure residents are groomed and receive dental care prior to coming for breakfast". The inspector interviewed an additional RPN on Nov 8/11 about resident grooming. It was stated "residents are to receive grooming prior to coming to the dining room for breakfast". The inspector asked the Administrator/DOC to come to the dining room during breakfast on Nov 8/11 to observe the residents who had not received their grooming. The Administrator reported "you are right, I see what you mean".

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 each resident of the home receives individualized personal care, including grooming on a daily basis, to be implemented voluntarily.

Issued on this 6th day of January, 2012

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

Diana Stenlund