

**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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**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Dec 20, 2019	2019_638542_0034	023197-19	Critical Incident System

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**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Van Daele  
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

JENNIFER LAURICELLA (542)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): December 17, 18, 2019.**

**One intake was completed, regarding improper/incompetent treatment of a resident.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC) and Personal Support Workers (PSWs).**

**The Inspector conducted observations of the provision of care provided to the residents, reviewed relevant resident health care records and the home's investigation files related to the CI report.**

**The following Inspection Protocols were used during this inspection:  
Falls Prevention  
Prevention of Abuse, Neglect and Retaliation**

**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**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
- (a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
  - (b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
  - (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out clear directions to staff and others who provided direct care to the resident.

A Critical Incident (CI) report was submitted to the Director, outlining that resident #001 was left unattended which resulted in them falling. Resident #001 was transferred to the hospital for an assessment, resulting in a significant change in health status.

Inspector #542 completed a review of resident #001's health care record. The care plan in place at the time of their fall indicated that they were assessed as a specific risk for falls. The care plan indicated several fall prevention interventions.

Inspector #542 conducted an interview with PSW #100 regarding resident #001's fall prevention interventions. PSW #100 indicated that resident #001 should not have been left unassisted due to their high risk for falls. Furthermore, resident #001 had fall prevention interventions included in their plan of care. They further indicated that the care plan for resident #001 did not indicate clear directions as to whether they could be left unattended.

Inspector #542 interviewed PSW #101 who indicated that they never left resident #001 unattended due to their risk of falls; however, they were unsure if this was included in the resident's plan of care.

Inspector #542 interviewed the Assistant Director of Care (ADOC) and the Director of Care (DOC) regarding the incident. The ADOC and DOC stated that resident #001 should not have been left unattended due to their high risk of falls. The ADOC indicated that the care plan should have been more clear regarding resident #001's fall prevention interventions. [s. 6. (1) (c)]

***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 there is a written plan of care for each resident that sets out, c) clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.***

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**Issued on this 20th day of December, 2019**

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

**Original report signed by the inspector.**