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
Jan 9, 2020	2020_640601_0001	015210-19, 018948-19, 023941-19	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 Cobourg
130 New Densmore Road COBOURG ON K9A 5W2

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

KARYN WOOD (601)

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 2, 3, 6 and 7, 2020.

The following intakes were completed in this Critical Incident Report (CIR) Inspection:

Three logs related to a fall that resulted in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physiotherapist Assistant (PA) and a resident.

The inspector also reviewed resident health care records, observed the delivery of resident care and services, including staff to resident interactions.

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

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	
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. (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 resident #002 that set out clear directions to staff and others who provided direct care to the resident.

A Critical Incident report was submitted to the Director related to an incident which occurred on a specified date and time. According to the CIR, resident #002 had a fall that resulted in an injury. The CIR further indicated the resident had been ambulating without staff assistance and was using a specified mobility device prior to the fall.

On a specified date, Inspector #601 observed resident #002 with specific falls interventions in place and a specified mobility device.

A review of resident #002's progress notes, by Inspector #601 during a specified period of time, identified that resident #002 had fallen on two occasions. Resident #002 sustained the identified injury following the second fall and the resident did not have staff assistance at the time of the fall.

A review of resident #002's falls and mobility care plan prior to the fall that resulted in the specified injury, by Inspector #601 identified the resident was at risk for falls. Resident #002's written care plan had specified interventions and these interventions did not provide clear direction whether the resident required staff assistance while ambulating, with their specified mobility device.

A review of resident #002's current falls and mobility care plan by Inspector #601, identified that no changes had been made to the resident's written care plan following their fall with the specified injury.

A review of resident #002's physio referral and physiotherapy assessment prior to the fall that resulted in the specified injury, by Inspector #601 identified the Physiotherapist had documented resident #002 was at risk for falls and specified staff assistance was required with transfers and while ambulating with their specified mobility device.

A review of resident #002's physio referral and physiotherapy assessment following the fall that resulted in the specified injury, by Inspector #601 identified the Physiotherapist had documented resident #002 had a change in the specified staff assistance for transfers and required staff assistance at times with the use of a mobility device for

locomotion.

During an interview on a specified date, resident #002 indicated to Inspector #601 that specified falls interventions were in place. The resident also indicated that a specified number of staff assist them with transfers and toileting but sometimes there would be a different specified number of staff providing the assistance.

During separate interviews on specified dates, PSW #107, PSW #108, RPN #105, RN #109 and PA #111 and review of the progress notes for a specified period by Inspector #601, identified that specific falls interventions had been utilized by staff to manage resident #002's risk for falls. Inspector #601 reviewed the current care plan and these interventions were not included in the resident's current written plan of care.

During separate interviews on specified dates, RPN #105, RN #109 and the Administrator indicated to Inspector #601 the resident's care plans were to be updated by the registered staff immediately following each fall, as required and the current interventions implemented to decrease resident #002's risk for falls was not documented in the resident's written care plan to provide clear direction to staff providing the resident's care.

The licensee did not ensure the written plan of care for resident #002 set out clear directions to staff and others who provided direct care to the resident. [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 residents that set out clear directions to staff and others who provided direct care to the residents, to be implemented voluntarily.

Issued on this 9th day of January, 2020

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

Original report signed by the inspector.