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**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111


## Public Copy/Copie du rapport public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Dec 17, 2019 | 2019_694166_0026 | 016716-19, 017139-19 | Complaint |

## 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 Oshawa
82 Park Road North OSHAWA ON L1J 4L1

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

CAROLINE TOMPKINS (166)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): November 26, 27, 28, 29, December 3, 2019**

**Complaint Logs,#016716-19 and #017139-19, related to resident care were inspected concurrently during this inspection.**

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

**During the course of this inspection, the Inspector reviewed specific residents' clinical health records, the licensee's investigation documentation and the licensee's policy related to Complaints and Customer Service.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Personal Support Services**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Related to resident #004:

A complaint related to the personal care of resident #004 was submitted to the Director by the resident's Substitute Decision Maker (SDM). A verbal complaint related to the personal care of resident #004 was also submitted to the licensee by resident #004's SDM.

Review of the complaint documentation, by Inspector #166, indicated that on a specified date, the SDM, received a phone call from resident #004, who was upset and indicated assistance for toileting and transfer had not been provided as required to meet the resident needs.

During an interview with Inspector #166, the SDM for resident #004, indicated they arrived at the home mid morning and found resident #004 still in bed. The SDM indicated the resident is usually up in the early morning and care is provided before the resident is assisted to the dining room for breakfast. The SDM indicated the resident had used the nurse call twice and was told someone would be into help, however staff did not return to assist the resident.

Review of the licensee's internal investigation report, by Inspector #166, indicated that on the specified date of the incident, resident #004's home area did not have the full compliment of staff and the nurse in charge did not ensure that staff from other areas were redeployed to help, as is the customary practice in this home area.

Inspector #166, interviewed resident #004, who indicated the on the date of the incident, the resident felt "forgotten" and was very upset.

Review of resident #004's plan of care, indicated resident #004, required assistance for transferring from the bed and for toileting.

Review of resident #004's clinical health records, the licensee's investigation documentation, interview with the resident, interview with the resident's SDM and the Management team, by Inspector #166, over the course of this inspection, indicated, that resident #004's plan, related to care was not provided to the resident on the specified date when resident #004 was not assisted out of bed for toilet use and therefore was not able to go to the dining room for breakfast.

The licensee has failed to ensure that care according to resident #004's needs, related to assistance with transfers from the bed and toileting were not provided to the resident as specified in the plan.

Related to resident #005:

A complaint from the SDM for resident #005 was submitted to the Director related to a fall from which resident #005 had sustained injuries and was transferred to the hospital for further treatment.

A Critical Incident Report (CIR) was submitted to the Director, by the licensee, reporting that resident #005 had an un-witnessed fall, sustained injuries and was transferred to the hospital.

Review of the complaint documentation by Inspector #166, indicated on a specified date, resident #005 was found on the floor and had sustained injuries that required transfer to the hospital for further assessment and treatment.

Review of resident #005's clinical health records and the licensee's investigation documentation, by Inspector #166, indicated on the date of resident #005's fall while passing the resident's room, PSW #105 heard a loud thud. The PSW checked the resident's room and found resident #005 on the floor. PSW #105 called for the assistance of a Registered staff, who assessed the resident.The physician was notified and directed staff to transfer the resident to the hospital for further assessment, where it was determined, the resident had sustained injuries related to the fall.

Review of resident #005's plan of care related to bed mobility/safety indicated that there were falls prevention interventions in place.

Review of the independent witness statements from RN #108 and from Registered Practical Nurse (RPN) #106, by Inspector #166, indicated, the falls prevention interventions, which were required to be used when the resident was in bed, as indicated in the resident's plan, were not in place on the date of resident #005's fall.

Review of the licensee's investigation documentation and during separate interviews with Inspector #166, the Administrator, the Director of Care and the Assistant Director of Care, who is the lead for the home's Fall Prevention Program, confirmed that the falls prevention interventions were not in place when resident #005 fell and sustained injuries

that required the resident to be transferred to the hospital.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan related to bed mobility and safety. [s. 6. (7)]

***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 the licensee shall ensure that the care set out in the plan of care is provided to resident #004 and resident #005 as specified in their plan, to be implemented voluntarily.***

---

**Issued on this 30th day of December, 2019**

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

**Original report signed by the inspector.**