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
Sep 9, 2021	2021_784762_0024	010650-21, 010751-21, 011210-21, 012532-21	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

MOSES NEELAM (762)

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): August 18-20, 23-27, 2021

The following intakes were completed in this compliant inspection:
Log/CIS, related to an incident after which the resident had a significant change in condition
Log, related to resident care and environmental issues
Log, related to temperature, staffing and resident care

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Environmental Services Manager (ESM), Quality Lead, Physician, Registered Practical Nurses (RPNs), and Personal Support workers (PSWs)

During the course of this inspection the inspector reviewed records, observed infection prevention and control practices, resident and staff interactions, and conducted observations on resident home areas

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Sufficient Staffing

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 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 when resident #003 had an incident, the resident was assessed and that where the condition or circumstances of the resident require, a post-incident assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for the incident.

A critical incident report (CIR) was submitted to the Director due to an incident. A review of the resident's electronic health record in point click care (PCC) indicated that a an assessment was not completed under the assessment tab after the incident. In separate interviews, Quality Lead #104 and RPN #109, indicated an assessment was to be completed after the incident as per the Long-Term Care home's (LTCH) practice and policy. Therefore, the resident was not assessed using the LTCH's clinical instrument for assessing the incident. As a result, there was a risk of the staff missing specific assessment areas when not using the clinically appropriate instrument for assessing the resident.

Sources: LTCH's Policy; Assessment tab in point click care; Critical incident report; Interviews with RPN #109 and Quality Lead #104 [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 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., to be implemented voluntarily.

Issued on this 9th day of September, 2021

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

Original report signed by the inspector.