Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / Registre no	Type of Inspection / Genre d’inspection
Aug 29, 2014	2014_270531_0019	O-003820-14	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

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

SUSAN DONNAN (531)

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 26, 2014

During the course of the inspection, the inspector(s) spoke with the substitute decision maker, four Personal Support Workers, a Registered Practical nurse, a Registered nurse, a Physician, the Director of Care, and the Administrator.

During the course of the inspection, the inspector(s) toured the home, reviewed resident health records, reviewed the communication response system report, reviewed the Falls prevention and management policy, pain management policy, and complaints log.

The following Inspection Protocols were used during this inspection:

Hospitalization and Change in Condition

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. (12) 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 explanation of the plan of care. 2007, c. 8, s. 6 (12).

Findings/Faits saillants :

1. The licesee has failed to comply with the Long-Term Care Homes Act 2007, c. 8, s. 6(12) whereby the resident's substitute decision-maker, or any other persons designated by the resident or substitute decision-maker were not given an explanation of the plan of care.

On a specified date in review of the physician orders Resident #1's medications were reviewed and adjusted.

On a particular date, an interview with S #107 and review of Resident #1's health record confirm that the adjustment in medication was implemented as prescribed without the substitute decision-maker being notified. [s. 6. (12)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 107 (3) (4) whereby the licensee failed to report an occurrence of an incident for which the person was taken to hospital to the Director in one business day.

On a particular date the documentation in the progress notes confirm that Resident #1 suffered a fall and a fall assessment was completed with no injuries noted.

On a specified date Resident #1's foot was assessed as being bruised and swollen requiring transfer to hospital.

On a specified date the Administrator and Director of Care confirm that the occurrence which significantly altered the resident's health status was not reported to the Director. [s. 107. (3) 4.]

Issued on this 12th day of September, 2014

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