Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 603
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 603
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 20, 21, 22, Oct 18, 19, 21, 2011	2011_057163_0015	Critical Incident

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE TENDERCARE
770 Great Northern Road, Sault Ste Marie, ON, P6A-5K7

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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Co-ordinator, registered nursing staff, personal support workers (PSWs) and residents.

During the course of the inspection, the inspector(s) observed staff to resident interactions and care, reviewed health care documentation, the home's policies and procedures, critical incident system documentation and staff training records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to reassess a resident when the resident's care needs changed. Review of Critical Incident documentation and of the health care record indicates that a resident was not reassessed after care needs changed. The most recent Quarterly MDS Assessment for a resident was completed in early August 2011. Falls subsequent to this assessment were experienced by this resident and were documented in their health care record. Progress notes, also subsequent to the assessment, indicated that this resident had significant cognitive change resulting in a referral to an outside health care agency. The progress notes, dated subsequent to the assessment, identified that behaviour mapping was started, constant care was being provided and a chair alarm was ordered.
Inspector interviewed the RAI Co-Ordinator on Sept 21/11 who indicated that a significant change assessment had not been completed on this resident after noticeable change and repeated falls and "it should have been started".[s.6 (10) (b)]
2. The licensee did not ensure that care set out in the plan of care is provided to the resident as specified in the plan. Mandatory Report documentation indicated that staff did not use the proper lift equipment and reposition the resident as required. The Mandatory Report also indicated that a particular lift was to be used and that the resident had specific needs with regards to repositioning.
On Sept 21/11 the inspector interviewed the Administrator regarding the same Mandatory report. The Administrator reported that staff involved did not follow the plan of care for a particular resident such as using the proper lift and providing the appropriate repositioning. The Administrator added "this is not what the care plan said".[s.6(7)]

Issued on this 21st day of October, 2011

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

Diana Stenlund.