Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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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
Jul 29, 2019	2019_587129_0010	033476-18, 000685-19, 007767-19	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 Hamilton
90 Chedmac Drive HAMILTON ON L9C 7S6

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

PHYLLIS HILTZ-BONTJE (129)

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): June 6, 7, 11, 12, 13, 14, 17, 18, 19, 21, 24, 25, 26, 2019.

The following complaint intakes were inspected:
033476-18 related to medication administration
007767-19 related to falls prevention and management of complaints
000685-19 related to provision of care, response to call bell and abuse

During the course of the inspection, the inspector(s) spoke with residents, resident family members, Personal Support Workers, Registered Practical Nurses, scheduling coordinator, two Registered Nurse clinical leads, Resident Assessment Instrument/Minimum Data Set (RAI-MDS) coordinator, Social Worker, Director of Care, and the Administrator.
During the course of this inspection the inspector observed residents and care provided to residents, reviewed clinical documentation, reviewed licensee's policies and procedures, reviewed investigative notes maintained by the home and reviewed staff training records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Minimizing of Restraining
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **11 WN(s)**
- **4 VPC(s)**
- **2 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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) that had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able, either physically or cognitively, to release themselves from, was only used if the use of the PASD was included in the resident's plan of care.

In accordance with the Long-Term Care Home Act (LTCHA)2007, c. 8, s. 33(4)," the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all the following were satisfied":
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5).

a) It was observed that care provided to resident #002 included the use of an identified PASD.
On an identified date in 2019, resident #002 was observed to be sitting in the home area and the identified PASD was noted to be in use. At this time, the resident appeared to attempt to release themselves from the PASD. The Director of Care (DOC) was notified of these observations and attended the resident.
On an identified date in 2019, staff entered a progress note in the computerized record at 1343 hours that indicated the identified PASD was in use for resident #002. At the time of this inspection, RPN #115 and PSW #105 indicated they believed the identified PASD was being use to aid in positioning of the resident.

The following subsequent observations were made:
-Five days after the above noted observation, resident #002 was noted to be sitting in the

home area and the identified PASD was noted to be in use.
-One day following the preceding observation, resident #002 was observed to be sitting in the home area, the identified PASD was in use and resident #002 was observed to attempt to release themselves from the PASD. At this time resident #002 was unable to release themselves from the PASD.
-Two days following the preceding observation, resident #002 was observed to be sitting in the home area and the identified PASD was noted to be in use.
-Two days following the receding observation, resident #002 was observed to be sitting in the home area, the identified PASD was in use and the resident was observed to make unsuccessful attempts to release themselves from the PASD.
At the time of this inspection a review of resident #002's written plan of care confirmed that a care focus, care goals or care interventions for the use of the identified PASD had not been established. The written plan of care also did not include a care focus related to the use of the identified PASD to aid in the positioning of the resident.
The Administrator was asked to provide verification that alternatives to the use of the identified PASD were considered, the name of the person who authorized the use of the identified PASD and consent for the use of the PASD. They acknowledged they were unable to provide the information requested.
Following discussions with the Administrator, RPN #115, PSW #105, observations of resident #002 and a review of the resident's clinical record, it was confirmed that not all of the requirements for the use of the identified PASD, specifically; alternatives to the use of the PASD had been considered, the use of the PASD had been approved and consent for the use of the PASD, had been satisfied prior to including this intervention in the resident's plan of care.

(b) It was observed that care provided to resident #003 included the use of an identified PASD.
A review of the resident's written plan of care indicated that a care focus related to the use of the identified PASD to assist positioning of the resident was initiated on an identified date in 2019.
Five days following the initiation of the PASD, resident #003 was observed to be sitting in the home are and the identified PASD was in use.
Following the above noted observation, Personal Support Worker (PSW) #116, confirmed they provided care to the resident and accompanied the Inspector to observe the resident. When asked if the resident was able to release themselves from the PASD, they indicated that they would not be able to release themselves from the identified PASD.
Following the above noted observation, Registered Practical Nurse (RPN) #117, who

acknowledged that they where the charge nurse on the home area, accompanied the Inspector to observe the resident. They confirmed that the identified PASD was used to assist positioning of the resident and the resident would not have been able to release themselves from the PASD.
At the time of this inspection, RPN #115 was asked to provide verification that alternatives to the use of the identified PASD had been considered. RPN #115 provided a document identified as "Least Restraint-Personal Assistive Service Device (PASD) Assessment". A review of the document indicated there was no evidence that alternatives to the use of the identified PASD had been considered. RPN #115 acknowledged that the above noted "Assessment" was completed after the Inspector had requested the information and did not identify if alternatives to the use of the identified PASD had been considered.
At the time of this inspection, on an identified date, resident #003 was observed to be sitting beside their bed and the identified PASD was in use. At this time resident #003 was noted to make three unsuccessful attempts to release themselves from the PASD.

The Administrator was asked to provide documentation to verify the name of the person who approved the use of the identified PASD and evidence that a consent for the use had been obtained. The Administrator acknowledged they were unable to comply with the request as there was no documentation to verify the above two requests.

Following discussions with the Administrator, RPN #117, RPN #115, PSW #116, observations of resident #003 and a review of the resident's clinical record it was confirmed that not all of the requirements for the use of the identified PASD for positioning the resident, specifically; alternatives to the use of the PASD had been considered, the use of the PASD had been approved and consent for the use of the PASD, had been satisfied prior to including this intervention in the resident's plan of care.

c) It was observed that care provide to resident #004 included the use of an identified PASD.
A review of resident #004's written plan of care included a care focus related to the use of a PASD to assist the positioning of the resident that was initiated on an identified date in 2019.
Ten days following the initiation of the identified PASD, the resident was noted to be sitting in the front lobby area and the PASD was noted to be in use. At this time, RPN #118 was asked to observe the resident and when asked if the resident would be able to release themselves from the PASD, they responded "no".

On the same day, the Administrator provided documentation to verify that the Physiotherapist had approved the use of the PASD and that consent for the use had been obtained. The Administrator verified that they were unable to provide evidence that alternatives to the use of the identified PASD had been considered prior to including it in resident #004's plan of care.
Following discussions with the Administrator, RPN #118, observations of resident #004 and a review of the resident's clinical record, it was confirmed that not all of the requirements for the use of the identified PASD, specifically; that alternatives to the use of the tilt wheelchair had been considered, prior to including this intervention in the resident's plan of care. [s. 33. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 failed to ensure that when resident #002 and resident #004 fell, the residents were assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

a) The licensee failed to ensure that when resident #002 fell they were assessed for injury.

Clinical documentation indicated that RPN #108 was called to resident #002's room on an identified date in 2019, where the resident was found lying on the floor. Clinical

documentation indicated that RPN #108 made observations about the environment, as well as documented the resident's statement that they experienced pain over two specific areas. RPN #108 also noted that the resident had facial grimacing upon transfer from the floor, vital signs were taken and the resident was administered an identified medication for complaints of pain. There was no clinical documentation that demonstrated RPN #108 completed an assessment of resident #002 specifically related to the areas the resident indicated were painful at the time of the fall. Throughout the remainder of the shift, the following shift or in the early part of the next shift there was no documentation to indicate RPN #108 or any other registered staff member completed an assessment for possible injuries the resident may have sustained after the resident both verbalized and demonstrated they experienced pain over two identified areas.
During an interview with resident #002's SDM and in documentation provided by the home, it was identified that RPN #108 had contacted the SDM to alert them that the resident had fallen and that the resident was "fine".

The following day when the resident's SDM visited, resident #002 indicated to them that they had pain over two identified areas and wished to go back to bed. When the resident was assisted back to bed the resident's SDM made observations of the resident and became concerned that the resident had sustained an injury from the fall. The SDM notified registered staff who assessed the resident and indicated they were going to request an diagnostic procedure.

The same day, the Physiotherapist was asked to assess the resident and documented in the clinical record that the resident looked as though they were in pain and other observations about the resident. The Physiotherapist documented that they informed the unit nurse and the Physician of their assessment and a concern that the resident may have sustained an injury.

The same day, the resident's Physician assessed the resident and documented the resident was noted to have pain over two identified areas when seen lying in bed, was a bit drowsy, experienced tenderness over an identified area and other observations of the resident. The Physician documented that their impression was that the resident had sustained an injury and order the resident be sent to the hospital.

Documentation provided at the time of this inspection indicated that the DOC spoke with RPN #108, related to the circumstances of the fall resident #002 experienced on the above identified date and spoke to them about the importance of completing a proper head to toe assessment, the risk of moving a resident when they were in pain and

completing documentation.

Resident #002 was not assessed for possible injuries for approximately 15 hours after the above noted fall. As a result of observations made and concerns raised by the resident's SDM, the resident was assessed by the Physiotherapist and the Physician who ordered the resident to be transferred to hospital, where it was identified that the resident had sustained an injury.

b) The licensee failed to ensure that when resident #004 fell a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A progress note documented in resident #004's clinical record indicated that on an identified date in 2019, the resident was found sitting on the floor on at their bedside. At that time the resident was noted to be orientated to name, confused but calm and co-operative, able to move all limbs with no complaints of pain and the resident denied hitting their head. The record did not contain all the information required in the licensee's Post Fall Assessment document.

At the time of this inspection, the Administrator was asked to provide a copy of the licensee's Post Fall Assessment-V3 document related to the above noted fall. The Administrator verified that a post fall assessment had not been completed using the licensee's post fall assessment tool and confirmed that it was their expectation that staff complete a post fall assessment using the Post Fall Assessment-V3 document when a resident had fallen.

The Administrator confirmed that staff did not complete a post fall assessment using the clinical tool identified in the licensee's policy following the fall resident #004 experienced on the identified date. [s. 49. (2)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to resident #002.

a) On an identified date, at 1115 hours, Inspector #129 noted a Personal Support Worker (PSW) providing care to resident #002.
A review of resident #002's written plan of care indicated that interventions for care included that the resident required physical assistance of two staff for transfers, toilet use and personal hygiene, as they had been identified at risk for falling.
During a discussion with PSW #105 they acknowledged that they portered the resident into their washroom, instructed the resident to use the grab bar to stand, pivot and sit on the toilet, which the resident did. They then asked the resident to use the grab bar to stand from the toilet, they provided care to the resident and the resident pivoted and sat in their chair. PSW #105 confirmed that they were the only person in the washroom with resident #002 during this activity.
Following a review of the resident's plan of care; specifically, the Kardex, PSW #105 verified that the current Kardex indicated the resident was to be provided with physical assistance of two staff when transferring, toileting and during the provision of personal hygiene.
Observations of care provided, a discussion with PSW #105 and a review of the written plan of care confirmed that the care set out in the plan of care had not been provided to resident #002 when two staff did not provide assistance to transfer, toilet and provide personal care to the resident.

b) During a discussion with resident #002 and their Substitute Decision Maker (SDM) during this inspection, it was observed that the resident, who was sitting in a chair did not have an identified device applied.

A review of the resident's written plan of care confirmed the plan included an intervention to; apply the identified device when the resident was sitting in a chair for their safety. This intervention was created four months prior to the above noted observation and was a current intervention in the plan of care at the time of the observation.
PSW #106 and PSW #107 who responded to the resident's nurse call system confirmed that the resident did not have the identified device in place while sitting in the chair.
Observations of resident #002's chair made by the inspector and resident #002's SDM, discussion with PSW #106 and PSW #107 who entered the resident's room at the time of the observation, as well as clinical documentation confirmed that the care set out in the plan of care had not provided to resident #002 when the identified device was not applied when the resident was sitting in a chair. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in plan of care for resident #002, resident #003 and resident #004 was documented.

a) Resident #002's written plan of care included a care focus related to the risk for falling that included an intervention/task to check the resident every hour. Specially, this intervention/task directed staff to check the resident hourly, to ask if they were in pain, to position the resident in a comfortable position when in bed, to make sure personal items and call bell were within reach and to ensure two identified falls interventions were in place.

Registered Practical Nurse (RPN) #115 confirmed that Personal Support Workers (PSW) would be responsible for the provision of this care and the documentation that this care was provided.

RPN #115 provided a computer printout of a "30 Day Look Back Report", to demonstrate PSW documentation of the provision care over a current 30 day period of time. RPN #115 confirmed the above noted documentation report did not document the provision of care set out in the resident's plan of care.

RPN #115 and clinical documentation confirmed that the provision of care set out in the plan of care for resident #002 had not been documented.

b) Resident #003's written plan of care included a care focus related to the risk for falling, which included an intervention/task to check the resident every 60 minutes for safety, ensure the resident was wearing proper safe footwear and two identified falls interventions were in place.

At the time of this inspection, RPN #115 was asked to provide documentation that the above noted care had been provided to resident #003. At that time RPN #115 acknowledged that the above noted care intervention/task for the resident was a current care plan intervention, however, this intervention/task had not been added as a "task" and therefore a documentation record had not been generated and there was no documentation of the provision of the above noted care.

RPN #115 and clinical documentation confirmed that the provision of the above noted care, in relation to 60-minute checks for the safety of resident #003 had not been documented.

c) Resident #004's written plan of care included care focus related to the risk for falling which included an intervention/task to check the resident every 60 minutes for safety to ensure the bed was in the lowest position and the call bell was within reach. The resident's plan of care also included a care focus related to the use of a Personal Assistive Services Device (PASD) that included an intervention/task that directed the resident was to be monitored every two hours for safety.

At the time of this inspection, the Administrator was asked to provide documentation of the provision of the above noted care for resident #004. The Administrator acknowledged they were unable to provide a "30 Day Look Back Report" or any other documentation of the provision of the specified care.

The Administrator, RPN #115 and clinical documentation verified that the provision of the above noted care for resident #002, resident #003 and resident #004 had not been documented. [s. 6. (9) 1.]

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 and ensuring that care set out in the plan of care is provided to residents as specified in the plan of care and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy and procedure that the policy and procedure was complied with.

a) The licensee failed to ensure that the policy and procedures included in the licensee's "Falls Prevention and Management Program", identified as #RC-15-01-01 and dated February 2017, were complied with.

In accordance with O. Reg. 79/10, s. 30 (1) 1, there must be a written description of the program that includes relevant policies for each of the interdisciplinary programs required under section 48 of Regulation 79/10.

In accordance with O. Reg. 79/10, s. 48 (1) 1, the licensee shall ensure an interdisciplinary falls prevention and management program to reduce the incidents of falls and the risk of injury is developed and implemented.

The procedure section of the above noted program document directed staff to:

Hold a Post-Fall Huddle in accordance with Post-Fall Team Huddle Process, Appendix 12. Appendix 12 directed staff to:

- Complete a Post Fall Assessment, which included an area to summarize the Post Fall Team Huddle.

- Implement all prevention measures identified in the Post Fall Team Huddle and update the Care Plan
- Complete mandatory additional steps as per Extendicare Falls Policies and Procedures – to include, documentation of incident and recommendations from Post Fall Team Huddle.

Staff did not comply with the above noted directions when the following was identified:

i) Clinical documentation indicated staff initiated Post Fall Assessments for resident #002 on four identified dates in 2019. Following a review of these four Post Fall Assessment-V3 clinical documents, RPN #115 acknowledged that the Post Fall Assessments did not include a documented summary of a Post Fall Team Huddle, there were no preventative measures identified and there were no identified updates to resident #002's plan of care identified, as required in the above noted policy.

ii) Clinical documentation indicated staff initiated Post Fall Assessments for resident #003 on four identified dates in 2019. Following a review of the above noted Post Fall Assessments-V3 documents at the time of this inspection, the DOC acknowledged that the Post Fall Assessments documents did not include a documented summary of a Post Fall Team Huddle, there were no preventative measures identified and there were no identified updates to resident #003's plan of care identified, as required in the above noted policy.

At the time of this inspection RPN #115 acknowledged they had previously noted that information related to the outcome of a post fall huddle was not being documented, the Post Fall Assessment-V3 document was not being completed as directed and they had shared this information with their supervisor.

The DOC, RPN #115 and clinical documentation confirmed that the licensee's procedure related to completing and documenting activities related to post fall assessments had not been complied with.

b) The licensee failed to ensure that the procedures related to the management and investigation of complaints identified in the licensee's policy "Complaints and Customer Services", #RC-09-01-04, last updated in April 2017, were not complied with.

In accordance with the Long-Term Care Homes Act , 2007, c. 8, s. 21 "Every licensee of a long-term care home shall ensure that there are written procedures that comply with

the regulations for initiating complaints to the licensee and for how the licensee deals with complaints".

The above noted policy directed:
-Interview all staff who may have information related to the complaint.
-Take notes of all interview questions, observations and other actions related to the investigation. See "Investigation Interview Form, Appendix 3.
-When possible, witness questions and statements should be written by the witness, dated and signed. See "Investigation Interview Form, Appendix 4.
-Keep all materials related to the investigation together in one file for future retrieval and quality improvement auditing purposes.

During a discussion with the Administrator and DOC at the time of this inspection, they were asked if they had interviewed the Registered Nurse (RN) who was documented as attending the "Huddle" following the incident resident #002 experienced on an identified date in 2019, and they indicated they had no documentation to indicate they had interviewed that staff person. The Administrator acknowledged that they were unable to provide documentation that was requested about the investigation related to actions taken with time frames, interviews and observations made related to the investigation and specific contacts made throughout their investigation because they had not utilized the package of forms identified as amendments to the licensee's policy. At the time of this inspection the Administrator provided the package of forms that included; Complaint Investigation Form, Investigation Observation Form and Investigation Interview Form.

The Administrator confirmed that staff involved in the management of the above noted complaint failed to comply with the licensees procedures for the completing and documenting activities and information related to the investigation of a complaint related to resident #002.

c) The licensee failed to ensure that directions contained in the licensee's policies related medication management, specifically, the management of Leave of Absence (LOA) medications were complied with.

In accordance with O. Reg. 79/10, s. 114 (2), "the licensee shall ensure that written policies and protocols are developed for the medication management system".

The Administrator provided the following two policies related to Medication Administration, specifically, the management of Leave of Absence (LOA) medications.

"Ordering Medication for Leave of Absence", identified as #4-6 with a date of June 2017, under section 4 - Ordering and Receiving Medications.
This policy was located in the Pharmacy Policy & Procedure Manual for LTC Homes - Medical Pharmacies and directed:
- Medication for LOAs are to be ordered in advance to allow safe preparation time.
-Order from the pharmacy by way of written request using the Drug Order Book or eMAR notification.
-Recommend completion of "Acceptance of LOA Medications" form prior to releasing medication.
The policy also contains a sample form identified as "Acceptance of LOA Medications".

"Leave of Absence Medications", identified as RC-16-01-23, last updated in February 2017.
This policy was identified as an Extendicare policy and provided the following directions. (The procedure begins with the statement "depending on the pharmacy policy")
-The "Unplanned LOA" section of the policy directs that medications will be provided in accordance with pharmacy policy.
-The nurse will review the medication profile and provide verbal and written directions for the medication administration with the resident or responsible party prior to release of the medication.
-The nurse will provide the resident/responsible party a copy of the completed LOA Absence form identifying the resident's medications.
- The original LOA Absence form will be filed in the resident's chart.

Resident #001's Substitute Decision Maker (SDM) contacted the home by telephone a week prior to a planned LOA on an identified date in 2018, and informed RPN #103 that resident #001 would be going on a LOA on a specified date in 2018. When the SDM arrived at the home to pick up the resident they were informed that not all of the resident's medications for the period of the LOA were available. Staff provided the SDM with the medication pouches that contained the medications the resident was to take on the day the resident was picked up from the home and told the SDM that they would have to return to the home for the remainder of the medications when the pharmacy resupplied medications to the home. Registered Nurse (RN) #114 documented in the clinical record that when they checked, there was no medication available and when they contacted the pharmacy, the pharmacy indicated they had not sent LOA medications for this resident and would be sending the weekly medications out as usual that evening.

Staff failed to implement the directions contained in the Pharmacy policy, "Ordering Medication for Leave of Absence" and the Extendicare policy, "Leave of Absence Medications", when:

i) RPN #103 did not comply with the direction that LOA medications were to be ordered in advance to allow safe preparation time. RPN #103 confirmed they received notice from resident #001's SDM a week prior to a planned LOA in 2018, they were provided with the specific date the resident would be picked from the home and they did not order medications from the pharmacy for the period of the LOA. Resident #001's SDM and clinical documentation confirmed that when the resident was picked up on the identified date there were not sufficient medications for the period of the LOA available.

ii) Resident #001's SDM and clinical records confirmed that registered staff had not completed the "Acceptance of LOA Medications" or the LOA Absence form for the medications provided to the resident's SDM at the time they left the home on an identified date in 2018.

Resident #001's SDM, a review of clinical documentation and records maintained by the home, as well as an interview with RPN #103 confirmed that staff had not complied with the licensee's policy for the preparation of LOA medications or the directions for documenting medications that were provided to the resident's SDM when they left the home to take resident #001 for a LOA on the identified date in 2018 . [s. 8. (1) (a),s. 8. (1) (b)]

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 and ensure that where the licensee is required to have, institute or otherwise put in place any plan, policy, protocol, procedure strategy or system that the that the plan, policy, protocol, procedure strategy or system is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint concerning the care of resident #002 was immediately forwarded to the Director.

a) Resident #002's Substitute Decision Maker (SDM) e-mailed a written complaint to the Director of Care (DOC) on an identified date in 2019. The written complaint indicated the SDM had concerns about an assessment of the resident, care not provided as planned, training provided to staff related to the management of falls and a request that the home implement an identified safety device to protect the resident.
Documents maintained by the home and provided at the time of this inspection, confirmed that the DOC forwarded the above noted e-mail complaint to the Administrator a day after they received it and the Administrator forwarded the written complaint to the Director a day later on an identified date.

The Administrator, DOC and documents maintained by the home confirmed that the above noted written complaint related to the care of resident #002 was not immediately forwarded to the Director, when the Director received notification of the above noted e-mail two days after the DOC received the e-mail from resident #002's SDM.

b) Resident #005's family member forwarded an e-mail to the home concerning the care of resident #005 on an identified date in 2019. The e-mail identified care concerns related staff not providing assistance for meals and assistance for personal care as well as staff speaking harshly to the resident.

Documents provided by the home confirmed the e-mail was forwarded to the Administrator the following day. The Administrator provided a Facsimile Cover Sheet that indicated the e-mail was forwarded to the Director a day after they received the e-mail.

The Administrator and records maintained by the home verified that the e-mail concerning the care of resident #005 was not immediately forwarded to the Director, when the Director received notification of the e-mail noted above one day after the Administrator received the above noted e-mail. [s. 22. (1)]

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 and ensuring that written complaints concerning the care of a resident or the operation of the long-term care home are immediately forwarded to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (1) Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section. 2007, c. 8, s. 76. (1).

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their performed their responsibilities before receiving training related to the duty under section 24 to make mandatory reports.

In accordance with the Long-Term Care Homes Act, 2017, c. 8, s. 76 (4), "every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations".

In accordance with O. Reg. 79/10, s. 219 (1), "the intervals for the purposes of subsection 76 (4) of the Act are annual intervals".

On an identified date , the Administrator verified that training related to the duty under section 24 to make mandatory reports was provided to staff through the training course "Zero Tolerance of Abuse and Neglect (A Module for ALL Staff)".
The Administrator provided a training report that indicated that 21 of 160 total staff (13.1 percent), did not receive training in the above noted area in 2018.

The Administrator and records maintained by the home confirmed that not all staff received training in the above noted area in accordance with the requirements. [s. 76. (2) 4.]

2. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in any other areas provided for in the regulations, specifically in the area of the licensee's written procedures for handling complaints and the role of staff in dealing with complaints.

In accordance with O. Reg. 79/10, s. 218 1, "for the purposes of paragraph 11 of subsection 76 (2) of the Act, additional areas in which training shall be provided include; The licensee's written procedures for handling complaints and the role of staff in dealing with complaints".

In accordance with the Long-Term Care Homes Act, 2017, c. 8, s. 76 (4), "every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations and O. Reg. 79/10, s. 219 (1), the intervals for the purposes of subsection

76 (4) of the Act are annual intervals".

The Administrator provided records of staff training in the area of the licensees' written procedures for handing complaints and the role of staff in dealing with complaints. The documents provided indicated that 21 of 160 total staff (13.1 percent), did not receive training in the area mentioned above.

The Administrator and documents maintained by the home confirmed that not all staff received training in the area of the licensee's written procedures for handling complaints and the role of staff in dealing with complaints in 2018. [s. 76. (2) 11.]

3. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with resident, training in any other areas provided for in the regulations, specifically training in the area of falls prevention and management.

In accordance with O. Reg, 79/10, s. 221 (1) 1, annual retraining in the area of falls prevention and management is required.

The Administrator provided records of staff training in the area of falls prevention and management. The documents provided indicated that 14 of 131 of staff who provided direct care to residents (10.69 percent), did not receive training in the above noted area in 2018.

The Administrator and documents maintained by the home confirmed that not all staff who provided direct care to residents received the required training in 2018. [s. 76. (7) 6.]

4. The licensee failed to ensure that all staff who provided direct care to residents receive, as a condition of continuing to have contact with residents, training in any other areas provided for in the regulations.

In accordance with O. Reg. s, 221(1) 6, training shall be provided to all staff who apply PASDs or monitory residents with PASDs, in the application, use and potential dangers of the PASDs.

In accordance with O. Reg. s, 221(2) 1, staff shall receive annual training in all the areas required under 76 (7) of the Act.

The Administrator provided documentation of training for all staff who provided direct care to residents in the area of "Restraint Minimization and PASDs" for 2018. The Administrator and documentation provided verified that 12 of 102 staff who provided direct care to residents (11.8 percent), did not receive training in the area of the application, use and potential dangers of the PASDs. The Administrator verified that this training is mandatory and staff are required to complete the training every year.

At the time of this inspection the Administrator and RN #114, who was the designated lead for the licensee's Orientation and Training Program, verified that the home did not have a process for assessing the individual learning needs of staff. [s. 76. (7) 6.]

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 and ensuring that all staff at the home have received training as required by this section, specifically, all staff receive annual retraining in the areas of the duty under section 24 to make mandatory reports and the licensee's written procedures for handling complaints and the role of staff in dealing with complaints, as well as all staff who provide direct care to residents receive annual retraining in the areas of falls prevention and management and the application, use and potential dangers of the PASDs, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The Administrator and the Director of Care (DOC) failed to immediately notify the Director when they had reasonable grounds to suspect that resident #002 had received improper care that resulted in a risk of injury and harm to the resident.

Clinical documentation, information provided by resident #002's Substitute Decision Marker (SDM) and records maintained by the home indicated resident #002's SDM was notified of an incident on an identified date in 2019, and at that time they had been assured by staff that the resident was fine. When the SDM visited the resident the following morning they noted the resident complained of pain over two identified areas and requested to go back to bed. When the resident was assisted into bed the SDM made an observation that caused them to be concerned that the resident had an injury. Following assessments completed later that morning by the Physiotherapist and resident #002's Physician, it was identified that the resident had sustained an injury, for which resident #002 was transferred to the hospital

The Administrator and the DOC had reasonable grounds to suspect that improper care of resident #002 occurred when the resident was not assessed for possible injuries following an incident that occurred on the identified date in 2019.
-Five days after the above noted incident, resident #002's SDM and another family member went to speak with the DOC about their concern related to the lack of care the resident had received following the incident; however the DOC was not in the home and

they spoke with the Social Worker (SW) about their concern. The SW communicated the family members concern to the DOC, three days later, when the DOC returned to work.
-The DOC contacted the SDM three days after receiving the information from the SW, and at that time the SDM expressed their concern about the care of the resident and why an injury had gone unnoticed for such a long period of time. The DOC indicated they would look into the issued and get back to the SDM.
-Documents provided by the home at the time of this inspection indicated that the DOC spoke with Registered Practical Nurse (RPN) #108 on an identified date, related to the noted incident resident #002 experienced. The recorded notes of this meeting indicated that completing a proper head to toe assessment, the risk of moving someone when they were in pain, proper documentation of an assessment including assessment of range of motion and pain assessment as well as not to move resident when in pain due to potential risk of further injury, were reviewed with the above noted RPN.
-The Administrator and the DOC were provided with reasonable grounds to suspect that resident #002 had received improper care when the resident's SDM sent an e-mail to the DOC, who then forwarded the e-mail Administrator. The concerns expressed in the email included; why the resident's injury from the incident was not noticed when care was provided for several hours after the resident was assisted to and out of bed. The e-mail included a number of questions they were requesting answers to that included; "when will a review of the incident be completed and communicated to them".

During a discussion with the Administrator and DOC, they acknowledged not completing an assessment of possible injuries resident #002 sustained following the identified incident, would be considered improper care of the resident.

At the time of this inspection, the DOC verified that the Director had not been informed of improper care provided to resident #002 following the identified incident when the resident was not assessed for possible injuries. [s. 24. (1) 1.]

2. The Administrator failed to ensure that when they had reasonable grounds to suspect that resident #005 was abused and neglected, this information was immediately reported to the Director.

On an identified date in 2019, the Administrator received an e-mail from a family member of resident #005 that indicated they believed there was “consistent and deliberate abuse” of the resident. The e-mail identified that the resident was not being provided the assistance they required for meals because they were being ignored by staff, on two occasions staff failed to provide assistance to the resident for a one and two hour period

of time, staff were ignoring the resident's call bell, as well as a situation were the family member heard a staff member speaking harshly to the resident.

The Administrator confirmed they had not notified the Director of the accusation that resident #005 was being consistently and deliberately abuse or the situations that lead resident #005's family member to inform the home of "consistent and deliberate abuse" of resident #005. [s. 24. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record related to the 2018 annual evaluation of the Falls Prevention and Management Program, included the date of the evaluation, a summary of changes made and the date those changes were implemented.

In accordance with O. Reg.79/10, s. 30 (1) and 30 (1) 3, 'the licensee shall ensure that the requirements are complied with in respect of each of the interdisciplinary programs under section 48 of this Regulation and the program must be evaluated and updated at least annually".

In accordance with O. Reg. 79/10, s. 48 (1) 1 the licensee is to ensure a Falls Prevention and Management Program is developed and implemented in the home.

Upon request the Administrator provided a copy of the written record related to the 2018 annual evaluation of the Falls Prevention and Management Program.
Following a review of the document provided the Administrator acknowledged that the document did not identify the date of the evaluation, a summary of changes made or the date changes were implemented. [s. 30. (1) 4.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a response to a complaint made by resident #002's SDM was responded to within 10 business days.

Resident #002's SDM initially expressed their concern that the resident had not been assessed following an incident, to the Social Worker (SW) on an identified date in 2019. At the time of this inspection the SW confirmed that they forwarded the concern to the DOC and the DOC confirmed that the SW had made them aware of the concern.

Documentation provided by the home at the time of the inspection indicated that four business days after the SW made the DOC aware of the concern, the DOC contacted the SDM, who indicated they wanted to know why no one had completed a thorough assessment of resident #002 after an incident or noticed that the resident had sustained an injury, for 12 hours after the incident.

Resident #002's SDM then submitted an e-mail complaint to the DOC thirteen business days after the above noted contact with the DOC, which indicated that as of that date they had not received an explanation of how the resident's injury was overlooked.

During a discussion with the resident's SDM at the time of this inspection, they verified that they had not had a response to the issues they raised with the SW or following contact with the DOC about their concerns regarding the care resident #002 received following the incident and that was why they submitted the e-mail complaint about the care related to the incident.

During a discussion with the DOC at the time of this inspection, they indicated that they thought they had contacted the complainant, but had no record to verify the contact.

Resident #002's SDM, the DOC and documents provided by the home confirmed that a response was not provided to a concern resident #002's SDM made concerning the care of the resident within 10 business days. [s. 101. (1) 1.]

2. The licensee failed to ensure that the documented record of every written or verbal complaint made to the licensee was reviewed and analyzed at least quarterly.

The Administrator acknowledged they were unable to provide a written record to verify that the documented record of every written or verbal complaint received was reviewed and analyzed because they had not completed quarterly reviews of the of the record of complaints received. [s. 101. (3)]

WN #10: 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. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later that on business day following an incident that caused an injury to resident #002 for which the resident was taken to hospital and that resulted in a significant change in the resident's health condition.

Resident #002's clinical record indicated that they experienced an incident on an identified date in 2019. Due to concerns raised by the resident's SDM the following day, the resident was assessed by the Physiotherapist. The Physiotherapist documented in the clinical record that the resident was in pain, made other observations of the resident and recommended an a diagnostic procedure related to a possible injury. The Physiotherapist shared their concern with the charge nurse and the resident's Physician. On the same day the Physician assessed the resident and documented observations of the resident and their impression that the resident had sustained an injury. The Physician order the resident be transferred to hospital for treatment of the injury. Resident #002 was transferred to hospital the same day, where it was confirmed that the resident had sustained an injury.
The DOC notified the Director through the submission of a Critical Incident Report (CIR) under the category "Incident that caused an injury to the resident for which the resident was transferred to hospital and which resulted in a significant change in the resident's health status, two business days following the resident's transfer to hospital.

The DOC and documentation maintained by the home confirmed the Director was not notified within one business day of an incident that caused an injury to resident #002 for which they were transferred to hospital and resulted in a significant change to the resident's health status. [s. 107. (3) 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (3) The licensee shall keep a written record relating to each evaluation under subsection (2) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 216 (3).

Findings/Faits saillants :

1. The licensee failed to keep a written record related to each to each evaluation that included the date of the evaluation and a summary of the changes made related to the training and orientation program for 2018.

In accordance with O. Reg. 79/10, s. 216 (1) and (2) "the licensee shall ensure a training and orientation program is developed and implemented" and "at least annually, the program is evaluated".

Upon request for the 2018 program evaluation for the training and orientation program, RN #114, who had been designated as the Training and Orientation Program lead, provided a document identified as "Quality Program Evaluation - Training and Orientation". The document provided did not identify the date of the evaluation or a summary of any changes made. [s. 216. (3)]

Issued on this 19th day of August, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2019_587129_0010
Log No. / No de registre :	033476-18, 000685-19, 007767-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Hamilton 90 Chedmac Drive, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Order / Ordre :

The licensee must be compliant with s. 33(3) of the Long-Term Care Homes Act 2007.

The licensee shall ensure that the Personal Assistive Services Device (PASD) used for resident #002, resident #003, resident #004 and any other residents is only used if:
-Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living,
-The use of the PASD has been approved by a person designated in the Act, and
-The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give the consent.

Grounds / Motifs :

1. The licensee failed to ensure that a Personal Assistance Services Device (PASD) that had the effect of limiting or inhibiting a resident's freedom of movement and the resident was not able, either physically or cognitively, to release themselves from, was only used if the use of the PASD was included in the resident's plan of care.

In accordance with the Long-Term Care Home Act (LTCHA)2007, c. 8, s. 33(4), the use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all the following were satisfied:

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5).

a) It was observed that care provided to resident #002 included the use of an identified PASD.
On an identified date in 2019, resident #002 was observed to be sitting in the home area and the identified PASD was in use. At this time, the resident appeared to attempt to release themselves from the PASD. The Director of Care (DOC) was notified of these observations and attended the resident.
Three months prior to the above noted observation, staff entered a progress note in the computerized record that indicated the identified PASD had been initiated and included in resident #002's plan of care.
At the time of this inspection, RPN #115 and PSW #105 indicated they believed the identified PASD was being used to aid in positioning of the resident.

The following subsequent of observations were made:
-Five days after the above noted observations, resident #002 was noted to be sitting in the home and the identified PASD was noted to be in use.
- One day following the above noted observation, resident #002 was observed to be sitting in home area, the identified PASD was in use and resident #002 was observed to attempt to release themselves from the PASD. At this time the

resident was unable to release themselves from the identified PASD.
- Two days following the above noted observation, resident #002 was observed to be sitting in the home area and the identified PASD was in use.
- Two days following the above noted observation, resident #002 was observed to be sitting in the home area and the identified PASD was in use. At this time the resident was noted to be unsuccessfully attempting to release themselves from the PASD

At the time of this inspection a review of resident #002's written plan of care confirmed that a care focus, care goals or care interventions for the use of the identified PASD had not been established.The written plan of care also did not include a care focus related to the use of the identified PASD as aid for positioning of the resident.

The Administrator was asked to provide verification that alternatives to the use of the identified PASD were considered, the name of the person who authorized the use of the PASD and consent for the use of the PASD. They acknowledged they were unable to provide the information requested.

Following discussions with the Administrator, RPN #115, PSW #105, observations of resident #002 and a review of the resident's clinical record it was confirmed that not all of the requirements for the use of the identified PASD, specifically; alternatives to the use of the PASD had been considered, the use of the PASD had been approved and consent for the use of the PASD,had been satisfied prior to including this intervention in the resident's plan of care.

b) It was observed that care provided to resident #003 included the use of an identified PASD.
A review of the resident's written plan of care indicated that a care focus related to the use of the identified PASD to assist positioning of the resident was initiated on an identified date in 2019.
Five days following the initiation of the identified PASD, resident #003 was observed at 0935 hours, to be sitting in the home area and the identified PASD was in use.
Following the above noted observation, Personal Support Worker (PSW) #116, confirmed they provided care to the resident and accompanied the Inspector to observe the resident. When asked if the resident was able to release themselves from the PASD they indicated the resident would not be able to release

themselves from the PASD.
Following the above noted observation, Registered Practical Nurse (RPN) #117, who acknowledged that they were the charge nurse on the home area, accompanied the Inspector to observe the resident. They confirmed that the identified PASD was being used as an aid to positioning of the resident and the resident would not be able to release themselves from the PASD.

At the time of this inspection, RPN #115 was asked to provide verification that alternatives to the use of the identified PASD had been considered. RPN #115 provided a document identified as "Least Restraint-Personal Assistive Service Device (PASD) Assessment". A review of the document indicated there was no evidence that alternatives to the use of the identified PASD had been considered. RPN #115 acknowledged that the above noted "Assessment" was completed after the Inspector had requested the information and did not identify if alternatives to the use of the tilt wheelchair had been considered.

On an identified date and time, resident #003 was observed to be sitting at the side of their bed and the identified PASD was in use. At this time the resident was noted to make three unsuccessful attempts to release themselves from the PASD.

The Administrator was asked to provide documentation to verify the name of the person who approved the use of the identified PASD and evidence that a consent for the use had been obtained. The Administrator acknowledged they were unable to comply with the request as there was no documentation to verify the above two requests.

Following discussions with the Administrator, RPN #117, RPN #115, PSW #116, observations of resident #003 and a review of the resident's clinical record it was confirmed that not all of the requirements for the use of the identified PASD, specifically; alternatives to the use of the PASD had been considered, the use of the PASD had been approved and consent for the use of the PASD, had been satisfied prior to including this intervention in the resident's plan of care.

c) It was observed that care provide to resident #004 included the use of an identified PASD.
A review of resident #004's written plan of care included a care focus related to

the use of a PASD to assist the positioning of the resident that was initiated on an identified date in 2019.

Eleven days following the initiation of the identified PASD in resident #003's plan of care, the resident was noted to be sitting in the front lobby area and the identified PASD was in use. At this time, RPN #118 was asked to observe the resident and when asked if the resident could easily release themselves from the PASD, they responded "no".

At the time of the inspection, the Administrator provided documentation to verify that the Physiotherapist had approved the use of the PASD and that consent for the use had been obtained. The Administrator verified that they were unable to provide evidence that alternatives to the use of the identified PASD had been considered prior to including it in resident #004's plan of care.

Following discussions with the Administrator, RPN #118, observations of resident #004 and a review of the resident's clinical record it was confirmed that not all of the requirements for the use of the PASD, specifically; that alternatives to the use of the identified PASD had been considered prior to including this intervention in the resident's plan of care.

d) The severity of this issue was determined to be a level 2, as there was minimal harm or risk of harm to residents. The scope of the issues was a level 3 (widespread), as it related to three of three residents reviewed. The home had a level 2 compliance history of one or more non-compliance, none of which were the same section or subsection being cited.

(129)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with s. 49(2) of Ontario Regulation 79/10.

The licensee shall ensure that when resident #002, resident #004 and any other resident have fallen, the resident is assessed, and a post fall assessment is completed using a clinically appropriate instrument identified by the licensee.

Grounds / Motifs :

1. a) The licensee failed to ensure that when resident #002 fell they were assessed for injury.

Clinical documentation indicated that RPN #108 was called to resident #002's room on an identified date at an identified time, where the resident was found lying on the floor. Clinical documentation indicated that RPN #108 made observations about the environment, as well as documented the resident's statement that they experienced pain over two identified areas. RPN #108 also noted that the resident had facial grimacing when transferred from the floor, vital signs were taken and the resident was administered an identified medication for complaints of pain. There was no clinical documentation that indicated RPN #108 completed an assessment of resident #002, specifically related to the areas the resident indicated were painful. Throughout the remainder of the identified shift, the following shift or in the early part of the next shift, there was no documentation to indicate RPN #108 or any other registered staff member completed an assessment for possible injuries the resident may have sustained in the fall after the resident both verbalized and demonstrated they experienced pain over two identified areas.

A review of documentation provided by the home and during an interview with resident #002's SDM, it was identified that RPN #108 had contacted them to alert them that the resident had fallen and that the resident was "fine".
The following morning when the resident's SDM visited, resident #002 indicated to them that they had pain over two identified areas and wished to go back to bed. When the resident was assisted back to bed the resident's SDM made observations of the resident that they felt may have indicated the resident had sustained an injury
The SDM notified registered staff who assessed the resident and indicated they were going to request a diagnostic procedure.
The Physiotherapist was asked to assess the resident and documented in the clinical record the day after the fall, that the resident looked as though they were in pain and other observations of the resident. The Physiotherapist documented that they informed the unit nurse and the Physician of their assessment and a concern that the resident may have sustained an identified injury.
The resident's physician assessed the resident shortly after and documented in the clinical record, that the resident was noted to have pain over two identified areas when lying in bed as well as other observations of resident #002. The Physician documented that their impression was the resident had sustained an identified injury and ordered the resident to be sent to the hospital.
At the time of this inspect documents of an investigation into the above noted incident by the DOC were provided and indicated that the DOC spoke with RPN #108 following the above noted incident. Records of the meeting with RPN #108 indicated the DOC spoke to RPN #108 about completing a proper head to toe assessment, the risk of moving someone when they were in pain, proper documentation of an assessment that included and assessment of range of motion, pain assessments as well as not moving a resident from the floor when in pain due to risk of injury, were discussed with RPN #108.

Registered staff failed to complete a physical assessment of possible injuries resident #002 sustained when they fell on an identified date. Resident #002's injuries were noted the following day when the resident was assessed by the Physiotherapist and resident #002's Physician, who ordered the resident to be transferred to hospital related to an identified injury.

b) The licensee failed to ensure that when resident #004 fell and where the condition or circumstances of the resident require, a post-fall assessment was

conducted using a clinically appropriate assessment instrument that was specifically designed for falls.
A progress note documented in resident #004's clinical record indicated that on an identified date the resident was found sitting on the floor at their bedside. At that time the resident was noted to be orientated to name, confused but calm and co-operative, able to move all limbs with no complaints of pain and the resident denied hitting their head. The record did not contain all the information required in the licensee's Post Fall Assessment document.
At the time of this inspection, the Administrator was asked to provide a copy of the licensee's Post Fall Assessment-V3 document related to the above noted fall. The Administrator verified that a post fall assessment had not been completed using the licensee's post fall assessment tool and confirmed that it was their expectation that staff complete a post fall assessment using the Post Fall Assessment-V3 document when a resident has fallen.
The Administrator confirmed that staff did not complete a post fall assessment using the clinical tool identified in the licensee's policy following the fall resident #004 experienced on the identified date.

c) The severity of this issue was determined to be a level 2, as there was minimal harm or risk of harm to the residents. The scope was identified as level 2 (pattern), as it related to two of three residents reviewed. The home had a level 3 history of one or more non-compliances, one of which was the same subsection cited, that included:
-Voluntary Plan of Corrective Action (VPC) issued on February 22, 2018, during Resident Quality Inspection (RQI) #2018_560632_0002.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

Service Area Office /
Bureau régional de services : Hamilton Service Area Office