Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 6, 2017	2017_590554_0010	002665-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAKEFIELD
19 FRASER STREET P. O. BOX 910 LAKEFIELD ON K0L 2H0

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

KELLY BURNS (554), BAIYE OROCK (624)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 28-31, and April 03-04, 2017

Resident Quality Inspection (RQI) #002665-17. The following intakes were reviewed and inspected concurrently with the RQI, intakes #032380-16, 032524-16, 000317-17, 004312-17, 004744-17 and, 005694-17.

Intake Summary:

1) #032380-16 - Complaint - multiple care issues;
2) #032524-16 - Critical Incident Report - alleged staff to resident abuse;
3) #000317-17 - Critical Incident Report - incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
4) #004312-17 - Critical Incident Report - incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
5) #004744-17 - Critical Incident Report - alleged staff to resident abuse;
6) #005694-17 - Critical Incident Report - alleged resident to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care, Clinical Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Activity Aid(s), Dietary Aid(s), Behaviour Supports Team (BSO), RAI-Coordinator, Quality Nurse, President of Family Council, President of Resident Council, Families, and Residents.

During the course of this inspection, the inspectors, toured the long-term care home, reviewed clinical health records, observed resident to resident interactions, staff to resident interactions, and observed medication administration and meal service; reviewed Resident Council Meeting Minutes, reviewed mandatory annual re-training statistics (specific to Resident Rights, zero tolerance of abuse and mandatory reporting), medication incidents and adverse drug reactions, licensee investigational notes and reviewed licensee specific policies, related to, Zero Tolerance of Abuse Program, Falls Prevention and Management Program, Responsive Behaviours, Pain Management, Lifts and Transfers, and Complaints and Customer Service.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The Licensee failed to ensure that care set out in the plan of care related to transfer of residents #029 and #031 was provided as specified in the resident's written plan of care.

Related to Intake #032380-16:

Resident #029 has a history which includes physical impairment and is at high risk for falls. Resident's #029's current plan of care for transfers states, total assistance: mechanical lift; two staff one to operate lift while second staff manoeuvres resident into wheelchair safely, using total lift with medium hammock sling.

Resident #031 has a history which includes physical impairment. Resident #031's current care plan for transfers, states that resident is total mechanical lift, with the aide of two staff; blue sling used; one staff to operate lift while other staff ensures resident is safely positioned during transfer; must cross leg straps for security; DO NOT leave sling under resident when in chair as slippery.

On April 03, 2017, at 1150 hours PSW #107 and #113 working during the identified shift were observed transferring resident #029 from bed to wheelchair with the mechanical lift using a large sling as confirmed by both PSWs. Both PSW's indicated that the care plan states that the resident uses a medium sling but because the medium slings are not usually available, they use the large sling. PSW #107 indicated that the expectation, if a medium sling is not found, he/she (PSW) is to notify his/her supervisor, and the RPN is to make sure a medium sling is located. The PSW indicated that he/she has not notified anyone of the absence of a medium sling for resident #029.

PSW #115 working the following shift, also indicated to Inspector #624 on April 03, 2017 at 1630 hours that the sling in the resident's room was a large sling and that resident #029 is supposed to have a medium sling. PSW #115, informed the RPN #116 who was unable to immediately locate the medium sling but promised to find a medium sling. A large sling was used to transfer resident #029. On April 04, 2017, a medium sling was found for the resident.

On April 04, 2017, at 0900 resident #031 was observed by Inspector #624 seating in the dining room in his/her wheelchair on top of a large mesh-like sling. In an interview with PSW #115, he/she indicated that resident use to have a nylon-like sling and it was this nylon-like sling that was not to be left in the wheelchair as it was slippery. PSW indicated that he/she has not seen the particular nylon-like sling in question but that the mesh like sling can be left under the resident. PSW indicated the assessed sling for resident #031 was not being used, as staff could not locate it.

In an interview with RPN #116 on April 03, 2017, and the DOC on April 04, 2017, by

Inspector #624, both indicated that the home's expectation is for care to be provided as written in the plan of care. The DOC was able to find resident #031's specific sling and indicated that this is the sling that is to be used for the resident. RPN #116 and the DOC indicated that the care, as written in the plan of care, was not provided to resident #031, related to the type of sling to be used.

The licensee failed to provide care to resident's #029 and #031 as specified in the plan of care related to lifts and transfers. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure there is a process in place and monitored, ensuring that the care set out in the plan of care is provided to the resident as specified in the plan, specifically related to lifts and transfers, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied.

Under O. Reg. 79/10, s. 48 (1) - Every licensee of a long-term care home shall ensure

that the following interdisciplinary programs are developed and implemented in the home, specifically, a falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee's policy, Falls Prevention and Management Program (#RC-06-04-01) directs that:
- A fall with injury will be immediately communicated to the Physician and or Nurse Practitioner.

Related to Intake #000317-17, for resident #026:

The Director of Care submitted a Critical Incident Report (CIR) on a specific date, for an incident that caused an injury to resident for which the resident was taken to hospital and which resulted in a significant change to the resident's health status. Resident #026 fell on an identified date and sustained injury.

Resident #026 has a history which includes cognitive impairment. Resident #026 requires extensive assistance for activities of daily living. Resident is identified as being at risk for falls.

The clinical health record, for resident #026, was reviewed for a period of six months, specific to resident's falls history, documenting that resident had fallen eight times during this period. The following documentation was identified:
- On an identified date and time (not incident in CIR) – Resident #026 was found on the floor, facing his/her wheelchair and was weeping. Resident stated "it hurt's all over", but specifically complained of a specific area being sore. Resident was assisted off of the floor using a mechanical lift, placed into his/her wheelchair and brought to nursing station for monitoring. Resident was observed to be rubbing a specific area on his/her body, and assessed by Registered Nurse-Charge Nurse #114 to have sustained an injury. RN #114 placed a note in physician book for review next visit.
- On a specified date (next day) – Resident had increased difficulty ambulating, was unable to walk with assistance to washroom. Complained of discomfort all over. Staff reported resident to be increasingly confused and having discomfort to a specific area.
- On a specific date (next day) – resident continued to complain of discomfort, and was not ambulating well to washroom.
- On a specific date (two days later) – Physician visited and assessed resident. Identified resident as having chronic discomfort, with a specific area being more of a focus. Medication was reviewed and changes made to medications related to pain

management.

The clinical health record provide supporting documentation that resident #024 was assessed by registered nursing staff and that routine analgesic was being provided to the resident during the dates of the above period.

Registered Nurse #106 indicated that the expectation is that a fall with injury is to be communicated as soon as possible either to the resident's physician or the on-call physician covering.

Registered Nurse #114 failed to comply with the licensee's policy, Falls Prevention and Management Program, by not immediately notifying the physician and or nurse practitioner of resident #024 falling on the identified date and sustaining injury. [s. 8. (1) (a),s. 8. (1) (b)]

2. Related to Intake #032380-16:

The licensee's Mechanical Lifts Policy #01-02, which is part of the Falls Prevention and Management Program (#RC-06-04-01), states under the policy statement that residents are assessed on admission, quarterly and with any change in condition.

According to the clinical health records of residents #029, #031 and #032, all three residents currently require total lifts for transfers from one surface to another. A review of the residents' clinical health records indicated that the most recent Resident Lift and Transfer Assessment was completed on a specific dates for resident #029, #031 and #032.

In an interview with RPN #116 on April 03, 2017, by inspector #624, he/she indicated that as per the licensee's policy, Lifts and Transfers assessments are to be completed quarterly in Point Click Care (PCC). RPN #116 further indicated that each of the identified assessments (listed and dated above), for residents #029, #031 and #032, were the last Lift and Transfers Assessment completed for these residents.

In an interview, the DOC (with the inspector, on April 04, 2017) indicated the licensee's expectation is that a quarterly lift and transfer assessment is to be completed, and indicated that the required quarterly lifts and transfers assessment were not completed as per the licensee's policy, Mechanical Lifts Policy, for residents #029, #031 and #032.

The licensee failed to comply with the Mechanical Lifts Policy. [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 to ensure there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically the Falls Prevention and Management program, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

The licensee's policy, Zero Tolerance of Abuse and Neglect: Response and Reporting (#RC-02-01-02) directs that all staff will:
- Immediately respond to any form of alleged, suspected or witnessed abuse;
- Intervene if safe to do so. Ensure the safety, and provide support of the abuse victim, through completion of full assessments, a determination of resident needs and a documented plan to meet those needs. Contact the physician and or nurse practitioner for further assessment if required and communicate the status of the resident.

Related to Intake #005694-17, related to Residents #024:

The Administrator submitted a Critical Incident Report (CIR) to the Director on a identified

date and time, regarding an incident of alleged resident to resident physical abuse.

The clinical health record, specifically progress notes, were reviewed for resident #024, for the identified date, documentation contained is as follows:

- Resident #024 was found (by nursing staff), on an identified date and at a specified hour, sitting on the floor, in the hallway, in an identified position. Resident#024 was complaining of discomfort, was assessed and identified to have injury. Registered Nurse #111, who was the Charge Nurse on shift, indicated in documentation, that resident #024 was furious and stated that resident #025 had stolen his/her money and had pushed him/her. RN #111 indicated in his/her documentation that SDM was to be notified in the morning of the alleged incident. At an indicated time (approximately 30 minutes post incident), RN #111 administered an analgesic, to resident #024, for generalized discomfort post incident. At an identified hour (60 minutes post incident), RN #111 indicated (in his/her documentation) that resident continued to complain of discomfort, and stated that the discomfort was "killing him/her", resident #024 remained agitated at the (alleged) actions of resident #025.

As per the clinical health record, resident #024 was transferred to hospital, by RN #106, at an identified hour (approximately seven hours later) and was assessed at hospital to require treatment and additional procedures.

The Director of Care indicated (to the inspector, on April 3, 2017) that RN #111 should have contacted the On-Call Physician as to the alleged resident to resident physical abuse and subsequent injury of resident #024 following the incident, noting resident's discomfort and complaints. [s. 20. (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 to ensure there is a process in place and monitored, ensuring the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #4: 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 Licensee failed to ensure that a person who had reasonable grounds to suspect any of the following has occurred or may occur, immediately report the suspicion and information upon which it was based to the Director, specifically abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) – For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, physical abuse means, the use of physical force by a resident that causes physical injury to another resident.

Related to Intake #005694-17, related to Residents #024 and #025:

The Administrator submitted a Critical Incident Report (CIR) to the Director on an identified date and time, regarding an incident of alleged resident to resident physical abuse.

Details of the CIR are as follows:

- On an identified date and time, Resident #024 was found (by nursing staff) sitting on the floor, in the hallway, in an identified position. A co-resident #025 was observed (by nursing staff) to be outside his/her room when resident #024 was found on the floor. Resident #024 indicated (to staff) that resident #025 had stolen his/her money and pushed him/her. Resident #024 complained of discomfort to a specific area, and was assessed by Registered Nurse (RN) #111 to have injury. RN #111, who was the Charge Nurse on shift, indicated in his/her documentation, that resident #024 was furious with resident #025. Resident was administered an analgesic, but continued to complain of discomfort. Resident was later (approximately seven hour later) transferred to hospital for assessment.

Registered Nurse #106, day Charge Nurse, indicated (to the inspector, March 31, 2017) that RN #111 reported to him/her (on the identified date) that resident #024 voiced allegations that resident #025 had pushed him/her to the floor. RN #106 indicated that he/she did not report this alleged abuse to Ministry of Health and Long-Term Care (MOHLTC). RN #106 indicated that he/she reported the alleged resident to resident abuse and subsequent injury of resident #024 to the Clinical Coordinator (CC), when CC came on shift later that afternoon.

There is no documentation to support that RN #111 reported the alleged resident to resident physical abuse to the Director (MOHLTC).

Registered Nurse #106 indicated that the expectation is that abuse and neglect is reportable to MOHLTC, and that the after-hours contact number is available for all Charge Nurse's to utilize.

The Director was not notified of the alleged resident to resident physical abuse for approximately thirteen hours post incident. [s. 24. (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 to ensure there is a process in place and monitored, ensuring hat a person who had reasonable grounds to suspect any of the following has occurred or may occur, immediately report the suspicion and information upon which it was based to the Director, specifically abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident that, resulted in a physical injury or pain to the resident, or caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

Related to Intake #005694-17, related to Residents #024:

The Administrator submitted a Critical Incident Report (CIR) to the Director on an identified date and time, regarding an incident of alleged resident to resident physical abuse.

Resident #024 has a history which includes cognitive impairment. Resident #024 requires assistance of staff for all activities of daily living. Resident #024 has a designated SDM for care (and financial) decisions.

Registered Nurse #106 indicated (to the inspector, on March 31, 2017) that resident #024 is unable to make care decisions, due to cognitive abilities and that Family #030 is the designated SDM for resident.

The clinical health record, specifically progress notes, were reviewed for resident #024, for the identified date, documented details are as follows:

- Resident #024 was found (by nursing staff), on an identified date and at a specified hour, sitting on the floor, in the hallway, in a specific position. Resident #024 was complaining of discomfort, and was assessed to have injury. Registered Nurse #111, who was the Charge Nurse on shift, indicated in documentation, that resident #024 was furious and stated that resident #025 had stolen his/her money and had pushed him/her. At an identified hour (30 minutes later), RN #111 administered an analgesic to resident #024, for generalized discomfort post fall. At an identified hour (60 minutes later), RN #111 indicated (in his/her documentation) that resident continued to complain of discomfort, and stated that pain was "killing him/her", resident #024 remained agitated at the alleged actions of resident #025. RN #111 indicated, in his/her documentation, that the SDM, for resident #024, was to be notified in the morning of the alleged physical abuse incident. At an identified time (approximately five hours later), an analgesic was re-administered. Resident continued to complain of discomfort to a specific area.

- At an identified time (approximately seven hours post incident), RN #106 documented that staff reported resident #024 to be nauseated upon movement, unable to get up and having complaints of severe discomfort. RN #106, who was the shift Charge Nurse, called SDM and the On Call Physician as to the alleged resident to resident physical abuse, with injury. Resident #024 was transferred to hospital for assessment. Resident #024 was assessed to have specific injury, was provided treatment and required additional procedures.

Registered Nurse #106 indicated (to the inspector, on March 31, 2017) resident #024's

SDM was not notified of the alleged abuse incident, and subsequent injury for approximately seven hours post allegation. [s. 97. (1) (a)]

Issued on this 6th day of April, 2017

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

Original report signed by the inspector.