Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Sep 18, 2015	2015_284545_0018	O-002399-15	Critical Incident System

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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 17 & 18, 2015

During the course of the inspection, the inspector(s) spoke with Resident #001, the Administrator, Director of Care (DOC), Social Worker, Admission Coordinator, RAI Super User, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Care Workers (PSW).

The inspector(s) also conducted a tour of the Resident care areas, reviewed the Investigation Report, reviewed Resident #001's health care records, observed Resident #001's room, observed Resident common areas, and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Responsive Behaviours

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

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the responsive behaviour plan of care based on an

interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day.

A Critical Incident Report (CIR) was submitted to the Director on a specific date in March 2015 for an incident involving Resident #001 reporting that care had not been provided on a specific date in March 2015.

In a review of the home's Investigation Report, it was documented that the Resident had been verbally abusive towards staff during care provision, and two days later apologized for her/his behaviour.

Resident #001 was admitted to the home on a specific date in February 2015 with many medical conditions, including a history of responsive behaviours. According to the Resident's health record, she/he was cognitively intact.

Upon review of Resident #001's health care records, documentation indicated that members of the home's health care team, including the Administrator, had met the Resident upon admission to discuss her/his behaviours and requirement for participation in the development of her/his Plan of Care.

Upon review of Resident #001's Admission Assessment it was documented that the Resident made negative statements about her/his medical status, staff and other residents, voiced numerous complaints about aspects of life in a facility. It was further documented that the Resident was impatient, demanding and verbally abusive, requiring a firm and consistent approach with set times and limits.

The SW provided the Inspector with the Resident's Plan of Care developed at time of admission. This Care Plan did not identify the Resident's moods and behaviours.

During an interview with the Social Worker (SW) #S100 on June 17, 2015, she indicated that the Admission Plan of Care did not include any mood and behaviour patterns, any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day, as exhibited by Resident #001 since admission.

On June 18, 2015, the Inspector interviewed several staff, they indicated the Resident was pleasant with periods of responsive behaviours, mostly related to care provision.

PSW #S105 indicated that two staff were required during provision of care. She added that this practice was encouraged due to the Resident's behaviours. PSW #S108 indicated that when Resident #001 was admitted, staff did not know how to approach the Resident. PSW added that the Resident was alert and directed own care, and was specific on how she/he wanted the care to be provided and when. RPN #S107 indicated that staff responded to the Resident's needs quickly as staff knew the Resident responsive behaviours could escalate, especially during care provision.

RN #S112 indicated on June 18, 2015 that she had reviewed the Admission Care Plan with the Resident, along with the Social Worker on a specific date in May 2015. She confirmed that the Care Plan did not include any of the exhibited responsive behaviours.

During an interview with the Director of Care (DOC) on June 18, 2015 she indicated that the Administrator had met with the Resident prior to the admission to the home and it was agreed that the Resident would be involved in her/his Plan of Care. The DOC further indicated that the Resident's responsive behaviours should have been included in the Plan of Care when the Resident was admitted to the home.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #001's responsive plan of care is based on an interdisciplinary assessment of the resident that includes: any mood and behaviour patterns, any identified responsive behaviours and any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

Issued on this 18th day of September, 2015

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

Original report signed by the inspector.