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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

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


## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 15, 2016 | 2016_200148_0002 | 034396-15, 032292-15, O-002476-15, O-002151-15, O-001837-15, O-001841-15, O-001692-15, O-002408-15 | 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

AMANDA NIXON (148), MELANIE SARRAZIN (592)

### 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): January 4-8 and January 11-13, 2015, on site.**

**During this critical incident inspection, a non-compliance was identified related to the repositioning of a resident while being restrained by a physical device. This non-compliance can be found under Complaint Inspection #2016 381592 0001, which was completed concurrently.**

**During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), both Assistant Directors of Care, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.**
**The inspectors reviewed resident health care records and information related to the licensee's investigation into critical incidents and observed resident/staff interaction and resident care.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the written plan of care for each resident sets out clear directions to staff and others who provide direct care to the resident. (Log O-001841-15)

Resident #002 is at high risk of falls, a Critical Incident report was submitted to the Director related to a fall in March 2015 that resulted in transfer to hospital. The resident has had known falls on several occasions in 2015.

The resident's plan of care, as it relates to fall risk, indicates that since early 2015, a bed alarm is applied on the bed and personal alarm applied when in bed. The plan of care describes that the resident uses a tilted wheelchair and is in bed at other times, depending on the resident's level of alertness as the resident will attempt to crawl out of bed if alert and awake. In addition, the fall risk plan of care indicates that since early 2015, the resident has a chair alarm placed on wheelchair for safety.

A review of the Fall Resident Assessment Protocols associated with the January and October 2015 Minimum Data Set assessment, indicates that the resident uses a personal alarm when up in chair and a bed alarm.

Observations of the resident by Inspector #148, confirmed the use of a chair alarm while resident was up in the wheelchair; PSW staff members #112 and #115, describe this as the resident's personal alarm. After the lunch meal the resident was placed in bed. Upon observation by the Inspector, the resident was alert and awake. The personal alarm had

been removed from the chair and was laying on the mattress to the side of the pillow, the cord clipped to the residents shirt at the shoulder. Inspector #148 approached RN #117, to discuss the use of the personal alarm in bed. RN #117 indicated that the resident has both a bed alarm, described as a pad that lays under the resident's sheets, and a personal alarm. She noted that the personal alarm is used on the chair and the bed alarm in the bed. RN and Inspector confirmed that there was no bed alarm in place. Upon further investigation it was noted that the alarm could be dragged along the length of the mattress by pulling the cord, without the cord dislodging from the alarm, as the personal alarm was not secured in one place. RN #117 and the Inspector determined that movement, including the residents ability to slid out of bed without alerting staff, were possible given the placement of the alarm. Inspector spoke with RPN #116, who is familiar with the resident, she indicated that she is aware that the resident had a bed alarm placed under the sheet for use in the bed prior to the resident's room change in the fall of 2015, in addition to the personal alarm used on the wheelchair. The Inspector spoke with PSW #112 who had placed the resident in bed, she indicated that the personal alarm is the same as the bed alarm, that they are the same device. A regular PSW on the floor, PSW #115, also indicated that the personal alarm is the same as the bed alarm.

In an interview with the home's DOC, it was clarified that the home has two types of alarms in use in the home; the personal alarm used for wheelchairs and sometimes used in bed and a bed alarm that is a pressure pad placed on the mattress.

The plan of care for Resident #002, does not provide for clear direction on the use of alarms for the residents safety when in bed.

The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.(Log 032292-15)

On a specified date, the home received a call at 1620 hours and was informed by a community member that Resident #001 had been found outside and had fallen, approximately 750 meters from the home by road. Staff were dispatched to the resident's location whereby the resident was found shaken and was sent to hospital for assessment. The resident was last seen by staff at approximately 1415 hours on the home's first floor. The evening RPN #100 had no report that the resident was out and the home's incident report indicates that the resident did not tell anyone that he/she was leaving the building.

The resident's plan of care at the time of the incident indicated that the resident had a Wanderguard and that staff were to check on the resident and sign a sheet for the resident, with regards to the Wanderguard. The plan of care item was added near the resident's admission to the home approximately 4 months prior to the incident described above, due to concerns that arose when the resident attempted to leave the floor. A review of a progress note dated days after the resident's admission, indicated that after discussion with the resident's POA for care, the Wanderguard was removed at the POA's request. There is no indication that the Wanderguard was used between the time of the POA's request and the date of the incident described above.

The plan of care at the time of the incident, indicated the use of a Wanderguard bracelet, however the bracelet was discontinued at the POAs request.

Interviews with registered nursing staff members, including RPN #101 and RPN #102, indicated that since the resident's admission, the resident has exhibited infrequent exit seeking. RPN #101 indicated that the resident is known to, at times, want to leave the building unattended. RPN #101 indicated that this poses a risk to the resident, as the resident may not be reliable to ensure his safe return due to his cognition, indicating specifically that the resident may get lost and not know his/her way back to the building.

A progress note dated days after the resident's admission, indicated that the resident left the building to go to the store and did not sign out or inform a staff member; the resident was brought back to the building by two community members. On the same date the registered nursing staff re- approached the resident's POA advising that the resident would benefit from the use of the Wanderguard. The POA did not feel this was necessary and reinforcement by the POA was provided to the resident to ensure that the resident informs staff when he/she intends to leave the building.

The plan of care at the time of the incident on a specified date described above, did not include indication of the residents safety risk, as it related to the resident's preference to leave the building, including the resident's ability to safely leave the building unattended and/or the residents reliability to inform staff of intentions to leave the building.

The most recent Minimum Data Set Assessment, indicated that the resident had deficits in cognition including short and long term memory loss and impaired decision making in new situations. In addition, the assessment indicated that the resident was admitted with a diagnosis of having an intellectual deficit which impairs communication abilities,

whereby the resident talks slowly and may need a moment to comprehend what is being said. Although the resident is usually understood and usually understands, the resident may miss part of the message if the speaker is not speaking slowly. In addition, admission notes indicated the resident is illiterate. Both Resident Assessment Protocols indicated that the items of cognition and communication would be care planned with appropriate goals.

Both the current plan of care and the plan of care in place at the time of the incident described above, do not include care planning on cognition or communication as required by the most recent MDS assessment. The incident report and staff interviews indicate the expectation that the resident will inform staff verbally when he/she intends to leave the floor or the building. Both the resident's cognition and communication abilities may impact on this expectation.

These examples indicate that the plan of care in place at the time of the incident described above, in addition to the current plan of care, were not based on the most recent assessment of the resident and the needs of that resident.

***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 the plan of care for Resident #001, is based on the resident's assessed needs including cognition, communication and safety risks, to be implemented voluntarily.***

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

**Specifically failed to comply with the following:**

**s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,**
**(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and**
**(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the Director was informed no later than three business days, of an incident that caused an injury to a resident for which the resident was taken to a hospital, but whereby the licensee was unable to determine within one business day whether the injury had resulted in a significant change to the resident's health condition. (Log O-002476-15)

In accordance with O.Reg, 79/10, s. 107 (7), a significant changes means a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition and requires an assessment by the interdisciplinary team or revision to the resident's plan of care.

Resident #003 was admitted to the home on a specified date. Three days after admission, the resident was found lying beside the resident's bed on the floor. The resident was sent to hospital on the same date due to pain in one hip and shortening of the leg. Registered nursing staff spoke with hospital staff, at which time the status of the resident was not determined. Progress notes indicate that the resident returned to the home six days after the incident. The health care record does not indicate that the staff were able to determine if the injury sustained at the time of the fall had resulted in a significant change.

Inspector #148 reviewed the incident with the home's DOC. After time to review the resident's file and speak with staff the DOC reported that the staff did not have the information to determine if the injury sustained related to the fall resulted in significant change. The incident occurred on a specified date and was reported to the Director on eight days later.

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**Issued on this 15th day of January, 2016**

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

**Original report signed by the inspector.**