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

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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
Jan 15, 2016	2016_381592_0001	O-002933-15, O-002915-15, O-002783-15, O-002761-15, O-002595-15, O-002561-15	Complaint

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

MELANIE SARRAZIN (592), AMANDA NIXON (148)

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): January 4, 5, 6, 7, 8, 11, 12 and 13, 2016

Logs #O-002933-15, O-002915-15, O-002783-15, O-002761-15, O-002595-15 and O-002561-15 were also inspected. Written notification #3 , related to the repositioning of residents while being restrained by a physical device, includes non-compliance identified during critical incident inspection #2016 200148 0002.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), both Assistant Directors of Care, Dietary Manager, Manager of Support Services, Maintenance staff, Social Worker, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers, Laundry Aid, residents and family members. In addition, the inspectors reviewed resident health care records and observed resident/staff interaction and resident care.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care

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

3 WN(s)
0 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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

Resident #007 resides in a semi-private room. The resident indicated that due to his/her physical condition, the resident is dressed and bathed in his/her bed. Upon further discussion the resident indicated concerns related to privacy during times of care provision in his/her bed.

Inspector #148 observed the resident's bedroom and noted that the privacy curtain nearest to the entry door did not meet the wall due to un-used hooks that remained on the track. This resulted in an obstruction that created an approximate six inch gap. The Inspector confirmed that this gap allows for a visual of the resident's bed from the hallway. Inspector #148 approached maintenance about the lack of privacy curtain in the resident's room. Maintenance Staff #139 moved the un-used hooks to allow the curtain to fully extend the length of the track. [s. 13.]

WN #2: 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 has failed to ensure that a person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (Log #009697-15)

On July 13, 2015, a family member of Resident #006 reported to the social worker that the resident described having his/her hair pulled by a PSW and that same PSW presents herself to be nice but is not nice with him/her. On that same day, the social worker forwarded directly the concern to the home's former ADOC.

Upon a review of the home's internal investigation, the home inquired further on July 20, 2015, and proceeded to conduct an investigation. The home could not verify that abuse had occurred.

Inspector #592 confirmed with the home's social worker that she met with the family member on July 13, 2015, wrote the concerns and met directly with the former ADOC at that time with the family member. She confirmed that the ADOC was the only person who was notified at the time and that the home's process is that the ADOC would go further and would notify the Administrator.

In an interview with the Administrator, she told inspector #592 that the incident was never communicated to her and that it should have been reported immediately to the Director, therefore ,the Director, under the LTCHA, was not notified of the suspected abuse reported by a family member pertaining to a suspected abuse on July 13, 2015. [s. 24. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.) O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is being restrained by a physical device that the resident is released from the physical device and repositioned at least once every two hours.

Resident #002 is restrained by use of a table top that clips in the back and a seat belt, while seated in a wheelchair. The position of the table top clip inhibits the resident from releasing the table top. Due to the position of the table top, the seat belt is rendered inaccessible to the resident to release. Both physical devices are ordered by a physician and are included in the resident's plan of care to prevent the resident from falls and injury.

On January 6, 2016, at approximately 0840 hours, Resident #002 was observed to be seated near the 2nd floor nursing station. Inspector #148 observed the resident between 0840 and 1100 hours. During this time the resident was not approached for release or repositioning. At 1100 hours the resident was toileted and thereby repositioned.

The November 2015 and January 2016 Restraint Records for Resident #002, indicated a pattern in which the physical restraints are applied at approximately 0800 hours and removed at 1300 hours and then reapplied from 1500 to 1900 hours. A review of the January 2016 Restraint Records indicates that between 0800 and 1300 hours the

resident was not released or repositioned on January 1 and 4, 2016 and was repositioned once on January 2, 3 and 5th. The Restraint Record for January 6, at the time of the Inspectors observations, confirm no release or repositioning was performed between 0800 and 1100 hours.
(Log O-001841-15) [s. 110. (2) 4.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and the licensee shall ensure that the following are documented: (Log #009697)

(7) every release of the device and all repositioning.

Resident #006's plan of care related to the use and application of an external device for prevention of injury indicates that Resident #006 requires a tray table with a lap belt when in wheelchair for meals. PSW to do hourly checks for safety and comfort and to repositioned Resident #006 every two hours and as needed.

On January 07, 2016, during an interview, PSW #118 indicated that the monitoring of restraints is documented in the restraint record form and that Resident #006 should be monitored each hour and repositioned each 2 hours when physical devices are applied.

Inspector #592 reviewed the resident's health care record and noted that on the restraint monitoring record, Resident #006 was not repositioned and the safety device not released every 2 hours.

The restraint monitoring form indicated a pattern for January 2, 3, 4 and 6, where the physical devices were documented to be applied at 0700 hours and no documentation was found for Resident #006 for the repositioning and the releasing of the physical devices until 1000 hours.

The restraint monitoring form also indicated a pattern for January 1, 2, 3, 5 and 6, where the physical devices were documented to be applied at 1000 hours and no documentation was found for Resident #006 for the repositioning and the releasing of the physical devices until 1300 hours.

The restraint monitoring form also indicated a pattern for January 2, 3 and 4, where the physical devices were documented to be applied at 1600 hours and no documentation

was found for Resident #006 for the repositioning and the releasing of the devices until 2100 hours.

The restraint monitoring form also indicated a pattern for January 1 and 6, where the physical devices were documented to be applied at 1600 hours and no documentation was found for the repositioning and the releasing of the devices until 2000 hours.

Inspector #592 spoke with RN #120 who indicated that there were no specific guidelines for the repositioning but that an hourly check of the resident is required and repositioning as needed.

Inspector #592 spoke with the DOC who indicated that the home's expectation is to have an hourly check done for each resident who are using safety devices and that resident should be repositioned every 2 hours including the release of the physical devices. The restraint monitoring documentation was reviewed and she confirmed that the PSW staffs did not document every release of the device and the repositioning for Resident #006. [s. 110. (7) 7.]

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.