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

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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
Jul 18, 2016	2016_380593_0018	014445-16, 017845-16	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

GILLIAN CHAMBERLIN (593)

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 17, 20 - 22, 24, 2016

Two complaints were inspected including #014445-16, related to resident care concerns and #017845-16, related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, Registered Nursing Staff, Dietary Staff, Maintenance Staff, Personal Support Workers (PSW), residents and family members.

The inspector observed the provision of care and services to residents, observed staff to resident interactions, observed resident to resident interactions, observed residents' environment, reviewed resident health care records, reviewed call bell communication records and reviewed home policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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 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. (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. (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 has failed to ensure that the written plan of care for sets out the planned care for resident #001 specifically related to the use of bed rails [014445-16].

A written complaint was received by the Director under the LTCHA from a family member related to the use of bed rails for resident #001. It was documented in the complaint that staff on multiple occasions have not raised the bed rails when resident #001 was in bed and they are concerned that they may try to get out of bed on their own or fall out of bed due to their medical history.

A review of resident #001's health care record found that the resident has medical history related to the family concerns.

A review of resident #001's plan of care found no documentation related to the use of the bed rails for safety or any other purpose when in bed.

A review of resident #001's flow sheets over a four month period, found that PSW's were documenting the use of two partial bed rails on some shifts however there was no documentation indicating that the resident required the use of two partial bed rails or the reason for their use.

During an interview with Inspector #593, June 21, 2016, PSW #101 who was the regular PSW on day shift for resident #001, reported that the bed rails were used to stop resident #001 from falling out of bed and to stop the resident from trying to get up on their own. When asked how the PSW knew to raise the bed rails when resident #001 was in bed,

the PSW responded that this intervention had been in place since they were first admitted and was implemented for their safety.

During an interview with Inspector #593, June 21, 2016, PSW #107 who was the primary PSW for resident #001 at that time, reported that they were unsure why resident #001 required bed rails when in bed. When asked how could they find out this information, the PSW was unsure.

During an interview with Inspector #593, June 22, 2016, the ADOC reported that as the bed rails have been requested by the family of resident #001 for safety, they should be documented in the plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan.

A review of resident #003’s care plan found that the resident required assistance due to their medical history. A goal was documented as: staff to assure resident is seated properly and the resident requires extensive assistance for transferring and repositioning.

On June 22, 2016, Inspector #593 observed resident #003 seated by the elevators in one of the home areas, calling out for assistance. The resident was heard to be saying "help me, I need to be repositioned". Resident #003 was asking resident #001 for assistance, resident #001 responded that they would like to help but could not because of their medical condition. Resident #001 was observed to call a PSW over to assist, the PSW was observed to ask resident #003 who usually takes care of them. Resident #003 responded PSW #101. The PSW told resident #003 that PSW #101 would help them when she returned from her break. Three other staff members were observed to walk past the resident as they were yelling for help to be repositioned. None of these staff members acknowledged the resident.

During this time, Inspector #593 observed resident #003 slumped over in their chair. When no staff were observed to be assisting resident #003, Inspector #593 approached RPN #110 and reported that the resident required assistance. RPN #110 left the area to locate a PSW, she then told resident #003 to go back to their room and they would be assisted. Resident #003 was then observed to ambulate in their wheelchair to their room, where PSW #101 returned from their break a few minutes later and assisted the resident.

The inspector observed that it was 17 minutes from the time the resident was first heard

calling for help to the time that they were assisted by a staff member.

During an interview with Inspector #593, June 22, 2016, when PSW #101 was told that the resident had been waiting for assistance, they responded that this always happen, they are supposed to be assisting and providing care to her residents while she is on her break however often they will report to her that a resident requires care while she is on her break rather than providing care to the resident at that time.

During an interview with Inspector #593, June 22, 2016, RPN #110 reported that it was the expectation that when PSWs are on their break, the other PSWs will cover for them. The RPN admitted that they were aware that some PSWs will wait until a PSW has returned from their break rather than provide immediate care to that resident.

During an interview with Inspector #593, June 22, 2016, ADOC #113 reported that the expectation of the home is that PSWs assist each other. They added that the residents welfare comes first and they should be providing immediate assistance to residents when required. [s. 6. (7)]

3. The licensee has failed to ensure that the care for resident #001 was to the resident as per the plan [014445-16].

A review of resident #001's current care plan found that the resident had a specific medical condition which required specific dietary interventions.

A review of the diet roster located in the level two servery, found documented the specific dietary restrictions for resident #001.

During the lunch meal service in one of the home areas on June 20, 2016, Inspector #593 observed resident #001 being served a meal. This meal did not adhere to the dietary restrictions documented in the resident's plan of care.

During the breakfast meal service in one of the home areas on June 21, 2016, Inspector #593 observed resident #001 being served a beverage by PSW #102. Inspector #593 inquired with PSW #102 about the type of beverage resident #001 was supposed to receive. PSW #102 initially said regular and then went and checked with Dietary Aide #105. They were then observed to replace resident #001's beverage with another. The resident was observed to drink approximately 20% of the first beverage before PSW #102 removed it from the table.

During an interview with Inspector #593, June 21, 2016, Dietary Aide #105 reported that staff are supposed to check the diet binder located at the cart, for resident dietary requirements.

Inspector #593 observed a diet roster located on the beverage cart in the level two dining room. It was documented on this roster that resident #001 could not have a particular beverage due to dietary restrictions. It was this beverage that was initially served to the resident.

During an interview with Inspector #593, June 21, 2016, Dietary Manager #103 reported that it was the expectation of the home that staff refer to the diet binders for all dietary requirements to ensure that the residents receive the correct food and fluids. When asked specifically about resident #001’s dietary requirements, #103 reported that what was documented could be confusing for staff however some residents had an individualized diet and resident #001 was one of them. Dietary Manager #103 reported that the nursing staff should be referring to the individualized diet sheets when serving the residents at meal times.

A review of resident #001’s individualized diet found documented for June 21, 2016, a meal that aligned with the resident's dietary requirements. The menu also had a note: please see diet sheet for diet and texture.

A review of the home’s policy titled: Tray Assembly and Service- DS-03-01-06, revised September, 2015, found that the dietary service staff are to refer to the diet list and therapeutic spreadsheet when plating meals for dining room service and trays as per resident selection. [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 ensuring that all planned care for each resident is included in the written plan of care and that all planned care for each resident is provident to the resident as per the plan, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that a verbal complaint made to the licensee concerning the care of resident #001, was responded to within 10 business days of the receipt of the complaint that complied with paragraph 3, being, i. what the licensee has done to resolve the complaint or, ii. that the licensee believes the complaint to be unfounded and the reasons for the belief [014445-16].

A written complaint was submitted to the Director under the LTCHA by a family member related to care concerns for resident #001. It was documented in the complaint that in early April, 2016, the family of resident #001 met with the Director of Care (DOC) to notify them of their concerns. It was documented that there had been no resolution from the DOC nor any follow up with the family from the DOC regarding their complaint.

During an interview with Inspector #593, June 20, 2016, family member #112 reported that they complained directly to the home in early April, 2016, regarding care concerns, however they have yet to receive a response regarding their complaint. Family member #112 reported that they were told by the DOC that they would get a response within 48 hours, however they have yet to receive a response more than two months after the care concerns were brought to the DOC.

A review of the home’s documented complaint records found two complaints documented in April, 2016 regarding care concerns for resident #001.

During an interview with Inspector #593, June 22, 2016, the DOC reported that verbal complaints were received from the family of resident #001 on two dates in April, 2016. The DOC confirmed that they never responded to the family.

A review of the home’s policy titled: “Complaints and Customer Service RC-11-01-04”, reviewed April 2016, found that staff will respond to all verbal or written concerns/complaints about the care of a resident or operation of the home. The home will comply with relevant regulatory requirements or provincial, regional, local health and other authority written directives regarding concerns/complaints. The management and resolution of issues will ensure residents, families, SDMs and other stakeholders receive a response within required legislative time frames and the addresses concerns are documented. [s. 101. (1) 1.]

Issued on this 18th day of July, 2016

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

Original report signed by the inspector.