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

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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
Oct 28, 2016	2016_330573_0024	015452-16, 020709-16, 028950-16, 029671-16, 029868-16	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

ANANDRAJ NATARAJAN (573)

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): October 19, 20, 21, 24, 25 and 26, 2016.

The purpose of this inspection was related to Log # 015452-16, 020709-16, 028950-16, 029671-16 and 029868-16 regarding resident to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC) / RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW).

During the course of the inspection, the inspector reviewed Critical Incident (CI) reports, reviewed residents health record (including care plans, progress notes, medication administration records, Geriatric Psychiatry Outreach reports), and home's internal investigation documentation. In addition the inspector observed the provision of care and services to residents, observed staff to resident interactions and observed resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #005's written plan of care set out clear direction to staff and others who provide direct care to the resident, specifically in relation to resident #005's wandering and physical responsive behaviours.

A critical incident report (CIR) was submitted to the Director regarding an incident of resident #005 to resident #006 alleged physical abuse that occurred on a specified date. The CIR indicated that resident #005 punched resident #006 on a specified body part. Resident #006 sustained injury and sent to hospital for further assessment. After 16 days a second CIR was submitted to the Director regarding an incident of resident #005 to resident #007 alleged physical abuse that occurred on a specified date.

Resident #005 was admitted in the home with responsive behaviours, resident #005 was assessed by the Home's Physician and by the Psycho Geriatric Team. Resident #005's medications were reassessed on an ongoing basis and readjusted to minimize the responsive behaviours.

Review of resident #005 nursing progress notes for two specific months in 2016, which included numerous documentation of resident #005's wandering into other resident rooms. The progress notes indicated that resident #005 gets upset and aggressive, towards staff and others when asked to leave the other residents room. For two specified months in 2016, there was ten nursing progress notes documented incidents where resident #005 exhibited physical aggression behaviours towards staff and residents on the unit.

On October 26, 2016, Inspector #573 reviewed resident #005's written plan of care in effect, which identifies that resident has responsive behaviours related to cognitive impairment. For wandering, it indicated staff to provide cues to assist in locating resident's room. Further the written plan of care failed to identify resident #005's wandering behaviour into other resident rooms. No specific interventions were in place to monitor the resident's whereabouts. Furthermore, there was no information or any interventions in place for staff regarding resident #005's physical aggressive responsive behaviours towards other residents and staff on the unit.

On October 26, 2016, during an interview with PSW #103, who indicated to Inspector #573 that she is not a regular PSW staff on the unit, that she was assigned to provide care to resident #005. PSW #103 indicated to inspector that during shift to shift report

she was not informed or made aware of any resident #005's responsive behaviours including the resident's physical responsive behaviours.

On October 26, 2016, the Inspector spoke with RPN #104 who indicated that resident #005's behaviours was managed with redirection and gentle approach. The RPN #104 indicated that resident #005 was currently on behaviour mapping, seen by the home's Behavioural Supports Ontario (BSO) team and Psycho Geriatric Team to manage resident responsive behaviours. Inspector #573 reviewed resident #005's written plan in the presence of RPN #104, after the review of resident #005's written plan of care, she indicated that the plan of care failed to identify resident #005's wandering behaviour into other resident room and also does not provide any information or interventions in place for staff regarding resident #005's physical aggressive responsive behaviours.

On October 26, 2016, Inspector #573 discussed the written plan of care in place for resident #005, revised on a specified date, in the presence of ADOC. After review, the ADOC indicated to Inspector #573 that resident #005's written plan of care does not identify nor provide clear direction for staff specifically related to resident #005's wandering behaviours into other resident rooms and resident's physical aggressive responsive behaviours towards staff and residents in the unit. (Log #028950- 16/ Log #029868-16) [s. 6. (1) (c)]

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 #005's written plan of care set out clear direction to staff and others who provide direct care to the resident, specifically in relation to resident #005's wandering and physical responsive behaviours and its interventions, to be implemented voluntarily.

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 had reasonable grounds to suspect that abuse of a resident by another resident which resulted in harm was not immediately reported to the Director.

A Critical Incident Report (CIR) was submitted to the Director regarding an alleged resident to resident verbal and physical abuse incident that occurred on a specified date.

Inspector #573 reviewed (CIR) which indicated that on a specified date and time, PSW #101 reported to RN #102 regarding an witnessed altercation between resident #001 and resident #003, where resident #001 become physical with resident #003. The CIR indicated that resident #003 called the police immediately to report the incident. Further the report indicated that resident #003's friend who witnessed the incident reported to the RN #102 that resident #001 punched resident #003's on a specific body part. RN #102 observed resident #003's with mild swelling in a specified body part and referred to home's physician for further assessment.

The home contacted MOHLTC after hours paging to report resident #001 to resident #003 verbal and physical abuse incident on a specified date and hours, which is more than 24 hours after the licensee become aware of the incident.

On October 25, 2016, during an interview with home's ADOC, who indicated to Inspector #573 that RN #102 was the in-charge registered nursing staff on duty at the time of incident. Further the ADOC indicated that the RN #102 failed to immediately report the incident to the Director.

A Compliance Order CO #001 in relation to mandatory reporting requirements was issued on June 30, 2016, with the compliance date on September 30, 2016, by Inspector #551 in Inspection Report #2016_290551_0008. (Log #028289-16) [s. 24. (1)]

Issued on this 15th day of November, 2016

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

Original report signed by the inspector.