



**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 rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2016	2016_289550_0033	028323-16	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

JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 21, 22, 23, 26, 29, 30, October 3, 4 and 5, 2016

This Complaint Inspection is related to abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW) and a family members.

In addition, the inspectors reviewed resident health care records and critical incident reports. The inspectors also observed resident care and services and staff and resident interaction.

**The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Pain
Personal Support Services**

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

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**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:**

8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :



1. The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

Resident #010 was admitted to the home with multiple medical conditions and passed away approximately 9 months later. Notes describing an incident written by the resident on a specific date were discovered by the resident's family member after the resident passed away.

Inspector #550 reviewed resident #010's health care records. The MDS assessment dated a specific date indicated that the resident was frequently incontinent of stools. A review of the resident's flow sheets for continence also revealed that the resident was frequently incontinent of stools.

During an interview, the ADOC indicated to the inspector that a continence assessment is done to all residents upon admission and quarterly thereafter; at the resident's MDS evaluation period. When a resident triggers for incontinence during the MDS assessment, the team is responsible for updating the resident's written plan of care. The ADOC reviewed resident #10's written plan of care dated a specific date in the presence of the inspector and observed that other than requiring assistance with toileting, there was no other identified interventions for bowel incontinence in the resident's plan of care.

As evidence above, resident #10's plan of care was not based on an interdisciplinary assessment of bowel incontinence. [s. 26. (3) 8.]

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 residents' plan of care are based on an interdisciplinary assessment of residents' continence, including bladder and bowel elimination, to be implemented voluntarily.



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Issued on this 10th day of November, 2016

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

Original report signed by the inspector.