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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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Aug 15, 2017 | 2017_627138_0021 | 004867-17, 006765-17, 006847-17, 007101-17, 009078-17, 010319-17, 012153-17, 014994-17, 018262-17 | 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**

PAULA MACDONALD (138)

## 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): July 21, 24, 25, 31, August 1, 2, 3, 4, 8, 9, 10, and 11, 2017.**

**The following Critical Incidents were inspected concurrently as part of this Critical Incident Inspection:**

**Log #004867-17 relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,**
**Log #006765-17 relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,**
**Log #006847-17 relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,**
**Log #007101-17 relating to an incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status,**
**Log #009078-17 relating to alleged resident abuse,**
**Log #010319-17 relating to alleged resident abuse,**
**Log #012153-17 relating to a missing resident >= 3 hours,**
**Log #014994-17 relating to alleged resident abuse and,**
**Log #018262-17 relating to alleged resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the acting Assistant Director of Care, the Quality Risk Management Coordinator, the Dietary Manager, a coder for Resident Assessment Instrument-Minimum Data Set (RAI-MDS), the Food Service Supervisor, the Social Worker, the DOC Clerk, the Physiotherapist, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), residents, and a Substitute Decision Maker (SDM).**

**The inspector also observed residents, observed resident rooms, reviewed health care records, reviewed the home's policy on falls management, reviewed the home's policy on missing residents, reviewed internal investigation documents, reviewed employee training dates, reviewed written communication to a physician, and reviewed a specific portion of the 24 hour report.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**
**Hospitalization and Change in Condition**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**
**Safe and Secure Home**

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

- **4 WN(s)**
- **3 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).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with section 6.(1)(c) of the Act in that 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.

The home submitted a Critical Incident Report to the Director (Ministry of Health and Long-Term Care) regarding resident #005, describing an incident in which resident #005 fell. The resident suffered an injury as a result of the fall.

Inspector #138 reviewed the health care record for resident #005, specifically the post fall assessment, which described that resident #005 fell. A factor of the fall identified in the post fall assessment was that the resident's seat belt had not been applied.

The inspector spoke separately with PSW #114 and RN #109. Both stated to the inspector that resident #005 wears a seat belt while in the wheelchair. PSW #114 stated that the resident could release the seat belt but RN #109 stated the opposite in that the resident would not be able to release the seat belt. However, both PSW #114 and RN #109 agreed that the resident used the seat belt as a falls prevention intervention and that this intervention has been in place for some time including at the time of the incident. The inspector spoke with the home's Physiotherapist who also stated that a seat belt was used for resident #005 as a safety measure for falls prevention.

The inspector further reviewed resident #005's health care record and was unable to locate any documentation that indicated the application of a seat belt for the resident when the resident was seated in a wheelchair. The inspector reviewed the plan of care (as defined by the home) for resident #005 that was in effect at the time of the incident as well as the current plan of care and noted that the there was no mention of the application of a seat belt while the resident was seated in a wheelchair.

As such, the licensee failed to ensure the written plan of care for resident #005 provided clear direction to staff and others who provide direct care to the resident regarding the application of a seat belt while the resident is seated in a wheelchair.

[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 resident #005's plan of care provides clear direction to staff regarding the use of a seat belt while seated in a wheelchair, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to comply with section 8.(1) (b) of the Regulation in that the licensee failed to ensure that where the Act or the Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with.

In accordance with this section, section 87. of the Act, and section 230. of the Regulation, every licensee shall ensure that there are emergency plans in place for the home including dealing with missing residents and that these emergency plans shall be complied with.

The home submitted a Critical Incident Report to the Director (Ministry of Health and Long-Term Care) describing an incident in which resident #007 was missing more than three hours.

Inspector #138 reviewed the health care record for resident #007 and viewed a progress note entered by RPN #124 indicating that resident #007 had left the home and would be returning at a specific time. RPN #124 then wrote another progress note stating that the resident was not back yet and that a message was left for the nurse from the next shift to follow up. RN #112, who was the nurse on the next shift, entered a progress note later that the resident went out of the home and was to be back at a specific time but had not returned. The progress note further stated that another search had been done, that the appropriate authorities were called (approximately eight hours after the resident was expected back in the home), and that a family member of resident #007 was called. Other progress note entries outlined that the appropriate authorities found the resident and that the resident was returned to the home.

Inspector #138 spoke with resident #007. Resident #007 explained to the inspector that s/he planned an outing and had made appropriate arrangements to be back at the home at a specific time. The resident stated that s/he was not able to get back to the home as planned and waited for the home to discover that s/he was missing as they would assist him/her back to the home.

The inspector spoke with the Director of Care about the home's emergency plan for missing residents and the Director of Care provided the written plan titled, "Code Yellow - Missing Resident" from the Emergency Preparedness and Response Manual. The inspector reviewed the written plan and noted that it outlined a very specific and time sensitive procedure to deal with missing residents including the completion of an emergency checklist for missing residents.

The inspector spoke with RPN #124 who first noticed that the resident had not returned as expected. RPN #124 stated to the inspector that he was aware that the resident was on an outing and had planned to be back at a specific time. RPN #124 stated that he noticed the resident had not returned as expected and was alerted because the resident was reliable in returning to the home as expected. The RPN stated that he conducted a search of the floor and the common areas used by the resident as soon as possible and was still unable to locate the resident. RPN #124 then tried to verify the resident's arrangements to return to the home but was unsuccessful. RPN #124 stated to the inspector that the resident was still not back at the change of shift and so the RPN reported to the RN of the next shift that the resident had not yet returned to the home. The inspector asked RPN #124 if he had initiated the emergency checklist for missing residents once it was noticed that resident #007 had not returned as expected and RPN

#124 stated that he did not as he was unaware of such checklist.

The inspector spoke with RN #112, the nurse from the next shift, and he confirmed that it was reported to him that resident #007 was expected back at the home at a specific time and had not returned. RN #112 stated that he waited several hours to conduct another search for the resident. RN #112 confirmed that the appropriate authorities were not called until approximately eight hours after the resident failed to return to the home as expected. RN #112 stated that the resident was found by the appropriate authorities who arranged for the resident's return to the home. RN #112 confirmed that resident #007 was found approximately ten hours after the resident was expected back at the home. RN #112 also confirmed that the resident returned to the home at approximately a half hour after being found by the appropriate authorities. The inspector asked RN #112 if an emergency checklist for missing residents was completed at anytime for resident #007 for this incident and RN #112 stated that no checklist had been completed.

As such, the licensee failed to comply with its written plan for missing residents when resident #007 did not return to the home as expected after a planned outing.

[s. 8. (1)]

***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 policy for missing resident is followed, to be implemented voluntarily.***

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**WN #3: 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:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The license has failed to comply with section 26.(3)19. of the Regulation in that the licensee has failed to ensure that a plan of care must be based on, at a minimum, interdisciplinary assessment of the safety risks with respect to the resident.

The home submitted a Critical Incident Report to the Director (Ministry of Health and Long-Term Care) regarding an incident in which resident #001 had been found off the grounds of the home with multiple care concerns.

Inspector #138 reviewed resident #001's health care record and noted that the resident has specific health risks, cognitive impairment, and specific and significant diagnosis. The progress notes show that the resident has the ability to leave the grounds of the home and will often do so via public transportation. Multiple staff stated that the resident will travel on public transportation at the discretion of the operator as the resident does not have fares for public transportation.

The inspector spoke with resident #001. Resident #001 stated that s/he enjoys leaving the grounds of the home. The inspector asked the resident if s/he carried any form of identification with him/her when leaving the grounds of the home and the resident stated that s/he did not carry any identification.

Inspector #138 spoke with RN #104 and PSW #103, both who stated to the inspector that the resident will come and go from the home without communicating the resident's intentions to the home. RN #104 and PSW #103 stated that it is difficult to know where the resident is and when to expect the resident back from any outings. RN #104 stated that resident #001 should have identification but was unaware, when told by the inspector, that the resident did not take any type of identification. RN #104 stated that she is aware that it is known that the resident travels off the grounds of the home at the discretion of the public transportation operator and stated that is possible for the resident to get stranded.

The inspector also spoke with the Social Worker for the home. The Social Worker stated that she was working to obtain reliable public transportation for the resident, however, this may not be possible due to specific factors. The Social Worker acknowledged that the resident continues to currently travel on public transportation without the proper fare.

The inspector also spoke with RN #107 and RN #109, on separate occasions. Both these RNs were on duty when resident #001 was found off the grounds of the home as outlined in the Critical Incident Report. Both RNs reported to the inspector that there was

no plan in place to ensure the return of the resident back to the home and both were required to call the Manager on Call for assistance. The inspector also spoke with the Dietary Manager, who confirmed that she was the Manager on Call at the time of the incident. The Dietary Manager stated that she received a call from RN #109 that resident #001 was off the grounds of the home and was required to be brought back to the home. The Dietary Manager confirmed that there was no plan in place to ensure the safe return of resident #001 to the home. RN #107, RN #109, and the Dietary Manager all stated that they felt that there needs to be a plan in place to ensure resident #001's safety when off the grounds of the home including safe return to the home should the resident not be able to return or in the event that something happened to the resident.

The inspector spoke with resident #001's Substitute Decision Maker (SDM) and the SDM stated that s/he feels that it is important to allow resident #001 the ability to leave the home but feels that there is a lack of interventions in place to ensure the resident's safety, reciting specific examples.

The inspector further reviewed resident #001's plan of care. It was noted that the plan of care did not identify an interdisciplinary assessment related to the safety risks associated with resident #001's ability to leave the grounds of the home, nor were there any interventions outlined as mentioned above by the SDM, RN #107, RN #109, and the Food Service Manager.

[s. 26. (3) 19.]

2. The home submitted a Critical Incident Report to the Director (Ministry of Health and Long Term Care) regarding an incident in which resident #007 was missing for more than three hours.

Inspector #138 reviewed resident #007's health care record and noted that the resident has specific and significant diagnosis. The progress notes demonstrates that the resident often leaves the grounds of the home via public transportation and communicates to staff the departure time as well as the time of the expected return to the home.

The inspector spoke with resident #007. Resident #007 stated that s/he makes his/her own arrangements to travel off the grounds of the home and will try to communicate to the home his/her arrangements including the departure and expected return. The resident stated to the inspector that, prior to this incident, the resident did not carry

identification nor did s/he have a plan in place in the event that the resident was unable to independently return to the home. The resident stated that since the incident, s/he now carries identification and has other interventions in place.

The inspector reviewed the plan of care for resident #007. It was noted that the plan of care did not identify an interdisciplinary assessment related to the safety risks associated with resident #007's ability to travel off the grounds of the home, nor did the plan of care outline any of the interventions put in place since the incident occurred.

[s. 26. (3) 19.]

***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 1) to ensure that the plan of care for resident #001 outlines an interdisciplinary assessment (which includes involvement of resident #001's SDM) of the resident's safety risks associated with leaving the grounds of the home and 2) to ensure that the plan of care for resident #007 also outlines an interdisciplinary assessment of the resident's safety risks associated with leaving the grounds of the home, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management**

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

**s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with section 49.(2) of the Regulation in that the licensee has failed to ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

The home submitted a Critical Incident Report to the Director (Ministry of Health and Long-Term Care) regarding an incident in which resident #003 sustained a witnessed fall that resulted in an injury for which the resident was sent to hospital.

Inspector #138 reviewed the health care record for resident #003 and noted that a progress note had been entered on the day of the fall, outlining that the resident had a witnessed fall with an injury in which resulted in a transfer to the hospital. The inspector was not able to locate the post fall assessment in the health care record for this specific fall.

The inspector spoke with RPN #110 regarding the practice in the home for post fall assessment and the RPN stated that every fall including those in which the resident is sent to hospital require a post fall assessment.

The inspector spoke with the Director of Care regarding falls management. The Director of Care provided the inspector with the home's policy on falls management which outlined that all falls, including those with a transfer to the hospital, require a post fall assessment. The Director of Care verified that there was no post fall assessment for resident #003's fall outlined in the Critical Incident Report.

[s. 49. (2)]

**Issued on this 16th day of August, 2017**

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

**Original report signed by the inspector.**