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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 22, 2018	2018_617148_0028	005692-18, 008426-18, 008442-18, 017935-18, 020402-18, 022617-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

AMANDA NIXON (148), LYNE DUCHESNE (117)

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): October 1-4, 9-12 and 15-17, 2018

This inspection included six complaint logs; Log 005692-18, 008426-18 and 008442-18 related to the provision of care and a fall pertaining to one identified resident; Log 017935-18 related to the care and services of an identified resident; Log 020402 -18 related to falls, toileting and infection control related to an identified resident; and Log 022617-18 related to an injury of an identified resident of unknown cause.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, both Assistant Directors of Care, Acting Director of Care, Support Services Manager, Scheduling Clerk, Registered Dietitian, two Physicians. Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide, family members and residents.

The Inspectors reviewed the health care records of identified residents along with pertinent program policies, as applicable. In addition, the Inspectors observed resident care and services, the resident's environment and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Nutrition and Hydration
Pain
Personal Support Services
Responsive Behaviours
Skin and Wound Care

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 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 :

The licensee has failed to ensure that where the Act or 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, is complied with.

In accordance with section 30 and 48 of O. Regulation 79/10, the licensee shall ensure that there is a falls prevention and management program in place to reduce the incidence of falls and the risk of injury. Further the licensee shall ensure that for each required program, including the falls prevention and management program, that there must be relevant policies, procedures and protocols for methods to reduce risk and monitor outcomes.

The home's Falls Prevention and Management Program, specifically policy RC-15-01-01, described that after a resident fall, an assessment of the resident is to be conducted followed by any required treatment or comfort measures. In addition, the physician and family are to be notified. The assessment conducted is to be documented on the Post Fall Assessment Tool and completed as soon as possible. If the fall is unwitnessed, clinical monitoring is to be implemented. Clinical monitoring includes the initiation of a head injury routine and 72 hour post fall monitoring to be completed at minimum each shift. Resident status is to be communicated at the end of shift.

Resident #001 was identified by the plan of care to have a risk for falls. On a specified date, the licensee submitted a critical incident report, describing that on the day previous,

the resident was found on the floor during the night shift. The resident was later sent to hospital by the evening RN #112, when the resident began to exhibit pain. The resident was sent out to hospital and was diagnosed with an injury. Night shift PSW #116, who discovered the resident, described to the Inspector that the resident was found in the resident's bedroom sitting on the fall mat with the resident's back to the bed. PSW #116 indicated that the resident was transferred back to the bed and at the time the resident was not exhibiting any pain or discomfort. A progress note written by RPN #109, indicated that the resident was found on the floor with no apparent injury and vitals signs stable. The Inspector reviewed the resident's health care record, whereby no documented by RPN #109 related to vitals or further fall assessment could be found. There was no record of an initiated head injury routine or monitoring every shift. During an interview with the Inspector, RPN #109 could not recall this incident or actions taken in response to the incident.

The Inspector spoke with RN #111, who was the day shift nurse on the identified date. RN #111 indicated that RPN #109 had described at shift report that resident #001 had been found out of bed but not on the floor. With this information, RN #111 did not take further actions as described by the falls management program. In an interview with RN #112, the RN reported that it was not until after the resident began to exhibit pain that RN #112 discovered that a fall had occurred during the previous night shift. RN #112 then initiated a post fall assessment and contacted the physician and the resident's family.

Resident #001 was not provided with a post fall assessment at the time of the fall nor were procedures followed related to the need for ongoing monitoring and reporting as indicated by the home's falls management program.
(Log 008426-18 and 008442-18)

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 plan, policy, protocol, procedure, strategy or system for the fall prevention and management program is complied with, 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:
3. A response shall be made to the person who made the complaint, indicating,
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. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to 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: 3. A response shall be made to the person who made the complaint, indicating, 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.

Resident #010 was admitted to the home on a specific day in 2018. The resident was noted to have several medical conditions and primarily mobilized with the assistance of a wheelchair.

On a specified day, nine days post admission, the resident's Substitute Decision Maker (SDM) took the resident on a leave of absence. Upon return to the home, the resident's SDM reported that the resident was expressing pain. Nursing staff RN #129 and RPN #130 assessed the resident. The attending physician #118 was contacted and medication and an x-ray were ordered. Two days later, the x-ray report was received by the home and the resident was identified as having an injury. The cause of the injury was unknown. The SDM was notified of the injury that same day.

The next day, the resident's SDM held a meeting with the home's attending physician #118, social worker and nursing team whereby the SDM brought forward numerous complaints regarding care concerns including the resident's ankle injury. The SDM then proceeded to discharge the resident from the home.

On October 9, 2018, the attending physician #118 and the ADOC #103 informed the Inspector that the home's DOC immediately initiated an internal complaint investigation into the reported care concerns, including the resident's injury. A review of the home's internal investigation report documents that the investigation was completed. There was no documentation to indicate that the results of the investigation were communicated to the resident's SDM. As per the ADOC #103, the ADOC was not aware of any communication held with the resident's SDM related to the reported care concerns.

As such, the licensee did not provide a response to resident #010's SDM in regards to the verbal complaint related to resident care and injury.
(Log # 022617-18)

Issued on this 23rd day of October, 2018

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

Original report signed by the inspector.