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 prévue 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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2019	2019_717531_0001	007280-18, 010759-18, 011695-18, 022305-18, 022616-18, 024413-18, 025030-18, 025231-18, 025945-18, 026768-18, 026769-18, 027470-18, 028183-18, 028315-18, 029167-18, 030201-18, 032408-18	Critical Incident System

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

SUSAN DONNAN (531), CATHI KERR (641)

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): January 7, 8, 9, 10, 11, 14, 15 and 16, 2019.

The following intakes where completed concurrently during this inspection:
Log #007280-18, CIS #2665-000028-18 related to infection prevention and control
Log #026769-18, CIS #2665-000089-18 related to alleged staff to resident physical abuse
Log #030201-18, CIS #2665-000100-18 related to alleged staff to resident care and services
Log #011695-18, CIS #2665-000056-18 related to alleged resident to resident sexual abuse
Log #022305-18, CIS #2665-000071-18 related to alleged staff to resident neglect
Log #022616-18, CIS #2665-000072-18 related to alleged resident to resident sexual abuse
Log #025030-18, CIS #2665-000076-18 related to alleged resident to resident sexual abuse
Log #029167-18, CIS #2665-000097-18 related to alleged resident to resident sexual abuse
Log #028183-18, CIS #2665-000091-18 related to alleged resident to resident sexual abuse
Log #028315-18, CIS #2665-000093-18 related to alleged resident to resident financial abuse
Log #025231-18, CIS #2665-000078-18 related to fall prevention
Log #032408-18, CIS #2665-000107-18 related to fall prevention
Log #024413-18 CIS #2665-000074-18 related to alleged resident to resident abuse
Log #027470-18, CIS #2665-000090-18 related to alleged financial abuse
Log #026768-18, CIS #2665-000088-18 related to alleged resident to resident physical abuse
Log #010759-18, CIS #2665-000049-18 related to falls prevention
Log #025945-18, CIS #2665-000081-18 related to alleged responsive behaviours

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Office Manager, residents' Substitute Decision Makers (SDM) and residents.

During the course of the inspection, the inspectors conducted a walking tour of the

home, observed resident care and services, reviewed resident health care records, reviewed critical incident reports and documentation, and reviewed the fall prevention policy and procedures, and reviewed the abuse policy and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende 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. (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 failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

This finding is related to intake log #030201-18 and critical incident #2665-000100-18 related to an incident that occurred on a specified date when PSW #125 attempted to toilet resident #016. Documentation in the critical incident indicated that PSW #125 transferred resident #016 alone instead of with two staff side by side as specified in the resident's care plan. The resident subsequently fell and sustained an injury.

During an interview with Inspector #641 on January 10, 2019 at 1525 hours, PSW #125 indicated that on the evening of the specified date, resident #016 was in the wheelchair and required toileting. The PSW advised that the other PSW on the unit was busy at the time. PSW #125 had positioned the resident by the toilet to be transferred when the resident reached out, grabbed the transfer pole and then fell onto the floor. PSW #125 indicated being aware that the resident required two staff for all transfers.

During an interview with Inspector #641 on January 10, 2019 at 1130 hours, PSW #123 indicated that resident #016 required two staff for transferring in and out of the wheelchair. The PSW specified that the resident could stand and hold onto a transfer pole to assist with the transfer. PSW #123 clarified that the resident would sometimes become weak, so it was important that the second staff member was there to assist and support the resident.

During an interview with Inspector #641 on January 9, 2019 at 1445 hours, the DOC indicated that from the investigation of the critical incident, PSW #125 had not transferred the resident with a second staff member as outlined in the resident's care plan. The resident had fallen as a result of this.

The licensee failed to ensure that the care set out in the plan of care for resident #016, to have two persons to assist for all transfers, was provided to the resident as specified in the plan. [s. 6. (7)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

This finding is related to intake log #026769-18 and critical incident #2665-000089-18 related to PSW #120 having completed care on resident #011 independently instead of with a second staff as specified in the resident's care plan.

During an interview with Inspector #641 on January 11, 2019 at 1120 hours, PSW #120

indicated having not worked with resident #011 prior to the evening of the specified date and did not know resident #011 or the plan of care. PSW #120 went into the resident's room and changed the resident unassisted. PSW #120 advised not being aware that the resident required two staff for all personal care.

During an interview with Inspector #641 on January 10, 2019 at 1515 hours, PSW #121 indicated having gone into resident #011's room at the time of the incident, noting that PSW #120 had changed the resident and put a sling under the resident, waiting for PSW #121 to assist with transferring the resident into a chair. PSW #121 specified having told PSW #120 that resident #011 required two staff for all care.

During an interview with Inspector #641 on January 9, 2019 at 1445 hours, the Director of Care (DOC) indicated that during the investigation into the incident, it became apparent to the DOC that PSW #120 had completed care on resident #011 independently, and not with another PSW as specified in the resident's care plan.

The licensee failed to ensure that resident #011 had all personal care completed by two staff, as specified in the resident's plan of care. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 21st day of January, 2019

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

Original report signed by the inspector.