Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 8, 2021	2020_593573_0022	002136-20, 002619-20, 003222-20, 003977-20, 004572-20, 005260-20, 015552-20, 015930-20, 018360-20	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

ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), LISA CUMMINGS (756), SUSAN LUI (178)

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): September 28 - 29, 2020, November 17 - 20, 23 - 27, 30, December 1 - 3, and 7, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:
Logs #002136-20, #002619-20, #003222-20, #005260-20 and #015552-20 were related to staff to resident alleged abuse and neglect.

Logs #004572-20 and #018360-20 were related to injury to the resident with unknown cause.

Log #003977-20 related to alleged resident to resident physical abuse.

Log #015930-20 related to a resident's medication incident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Clinical Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and the residents.

During the course of the inspection, the inspector(s) reviewed the identified resident's health care records, relevant home policies and procedures, and other pertinent documents. In addition, the inspectors observed the provision of care to the residents and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **2 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. 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 has reasonable grounds to suspect that abuse of residents has occurred or may occur reports immediately the suspicion and the information upon which it is based to the Director.

A PSW, RPN and RN had reasonable grounds to suspect that physical and verbal abuse may have occurred by PSW towards a resident. The alleged incident of physical and verbal abuse was not immediately reported to the Director.

Sources: Written statements of the staff members and interviews with the staff.

2. RPN had reasonable grounds to suspect that verbal abuse may have occurred by the PSW towards a resident. The alleged incident of verbal abuse was not immediately reported to the Director.

Sources: Interview with the staff. [s. 24. (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 a person who has reasonable grounds to suspect that abuse of a resident has occurred or may occur reports immediately the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to the resident under a program, including interventions and the resident's responses to interventions, are documented.

Resident was to receive a wound treatment and dressing change. A review of the electronic Treatment Administration Record and progress notes for the resident, revealed no documentation whether or not the wound treatment was provided, or the resident's response to the treatment.

Sources: Medical record for the resident; interviews with the staff. [s. 30. (2)]

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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #3: 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).

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 written plan of care for the resident sets out the planned care for the resident.

The plan of care for mood and behaviour for the resident directed staff to provide distraction, to ensure care is provided by two staff members and that a staff member provide direction to the resident during care.

Two PSWs described interventions including late morning rise, one-person care and to approach conversation with the resident in the form of questions, as successful methods in managing resistance to care and aggression. This planned care was not set out in the plan of care.

Sources: Resident's plan of care, interview with the staff. [s. 6. (1) (a)]

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

Resident’s plan of care indicated that the resident required two staff extensive assistance for the change of incontinent product and for the application of topical creams. During an interview, the PSW stated that they change the resident’s incontinent product and apply the topical cream independently without the second staff member assistance. The PSW did not followed the specified resident’s plan of care, therefore there was a potential risk for harm to the resident.

Sources: Resident's plan of care, interview with the staff members. [s. 6. (7)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with as it relates to the resident and alleged verbal abuse.

Specifically, staff did not comply with the home's policy and procedure, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting dated April 2017.

RPN had reasonable grounds to suspect that verbal abuse may have occurred by the PSW towards a resident. The RPN did not immediately report the alleged verbal abuse to the most senior supervisor on shift.

Sources: Zero Tolerance of Resident Abuse and Neglect: Response and Reporting (dated April 2017) and interviews with the staff. [s. 20. (1)]

WN #5: 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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for the resident was based on an assessment of mood and behavior patterns.

Resident was assessed to require a plan of care for their physical aggression and resistance to care. The resident was re assessed as requiring a plan of care for mood, which included persistent anger. It was nine months after the re assessment the plan of care for the resident's mood was initiated.

Sources: Plan of care for the resident and Minimum Data Set (MDS) Assessments for the resident. [s. 26. (3) 5.]

Issued on this 12th day of January, 2021

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

Original report signed by the inspector.