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
Mar 11, 2022	2022_627004_0003	015697-21, 015937-21, 016391-21, 016744-21, 002712-22	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

GURPREET GILL (705004), AMANDA NIXON (148)

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): February 22, 23, 24, 25, March 1, 2, 3, 4, and 7, 2022.

The following intakes were inspected in this Critical Incident System (CIS) inspection:
Log # 015697-21 (CI: 2665-000018-21) and 016744-21 (CI: 2665-000021-21) related to alleged resident to resident sexual abuse.
Log # 015937-21 (CI: 2665-000019-21) related to alleged staff to resident abuse and neglect
Log # 016391-21(CI: 2665-000020-21) related to medication incident
Log # 002712-22 (CI: 2665-000005-22) related to choking incident that resulted in harm to a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Assistant Director of Care/the Infection Prevention & Control (IPAC) Lead, Registered Nurses (RNs), Registered Dietitian (RD), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), RAI Coordinator and residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Nutrition and Hydration
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. (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 failed to ensure that the written plan of care for the resident set out the planned care for the resident.

The resident's clinical records identified that the resident had responsive behaviors, including socially inappropriate behaviour. The resident's plan of care included the focus of responsive behaviors but had not identified the resident's socially inappropriate behaviour. Furthermore, no interventions were identified for the staff regarding how to respond or manage the resident's socially inappropriate behaviour.

A Registered Nurse (RN) and two Registered Practical Nurses (RPNs) described interventions in place but this planned care was not set out in the resident's plan of care.

The lack of setting out the planned care for the resident placed a potential risk of harm to the residents.

Sources: The resident's plan of care, interviews with identified staff members. [s. 6. (1) (a)]

2. The licensee failed to ensure that the written plan of care for the resident set out clear directions to staff and others who provide direct care to the resident.

The plan of care for the resident included directions to staff to monitor closely. The health care record for the resident describes the resident with swallowing and choking risks.

In discussion with the Registered Dietitian and two Personal Support Workers (PSWs) the directions to monitor closely were not clear to staff, as staff were not able to describe how such an intervention was to be implemented for the resident. On a day in February

2022, the resident was provided with intermittent monitoring during the lunch meal while eating in the resident's room.

Another resident was identified to have similar risk factors for swallowing and choking. The plan of care for another resident who was also identified at risk for swallowing and choking had similar directions to staff. The resident was provided with constant monitoring while eating in the resident's room related to choking risk.

The lack of clarity of direction for the monitoring of residents may increase the risk of harm to residents where adequate monitoring is not provided.

Sources: Health care record review of residents, interviews with PSWs and the Registered Dietitian, observation of the lunch meal service on a day in February 2022. [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 that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 30th day of March, 2022

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

Original report signed by the inspector.