Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
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Original Public Report

Report Issue Date: April 5, 2023

Inspection Number: 2023-1171-0002

Inspection Type:
Complaint
Follow up
Critical Incident System

Licensee: Extendicare (Canada) Inc.

Long Term Care Home and City: Extendicare Laurier Manor, Gloucester

Lead Inspector	**Inspector Digital Signature**
Severn Brown (740785)	Severn Brown Digitally signed by Severn Brown Date: 2023.04.05 15:40:06 -04'00'

Additional Inspector(s)
Emily Prior (732)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
March 3, 6-10, 2023

The following intake(s) were inspected:

- Intake: #00020907 - Follow-up #: 1 Compliance Order #001 from inspection 2022-1171-0001 - O.Reg. 246/22 - s. 123 (2)
- Intake: #00019005 - IL-09525-AH/2665-000006-23 Unwitnessed fall resulting in injury and change of status to resident,
- Intake: #00019434 - IL-09685-OT Complaint alleging staff to resident abuse
- Intake: #00020927 - IL-10306-OT Complaint regarding food temperatures and resident feeding

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order # from Inspection #2022-1171-0001 related to O. Reg. 246/22, s. 123 (2) inspected by Severn Brown (740785)

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

Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to the Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure that an allegation of staff to resident abuse was immediately reported to the director.

Rationale and summary
A family member of a resident reported to an RPN (Registered Practical Nurse) in the home that the resident made had made an allegation that a staff member abused them. The RPN who had the allegation reported to them stated they responded to the allegation by immediately starting an investigation and reporting it to the responding Registered Nurse (RN). The RN failed to ensure that the Director was informed of an allegation of an abuse incident towards a resident immediately upon being informed of an allegation of abuse. The abuse allegation made by the resident was not reported to the Director until the following day by a different RN.

Risk statement
By not reporting an incident of abuse immediately to the Director, residents are put at risk of not

receiving the resources and supports required when reporting an incident of abuse or neglect.

Sources
Interviews with the RPN and RN, and the ADOC.
The resident's medication record
The Unusual Occurrence Report related to the incident
Infoline - LTC Homes After Hours Report related to the incident.

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WRITTEN NOTIFICATION: Improper transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 40

The licensee failed to ensure that a PSW (Personal Support Worker) used safe transferring techniques when assisting a resident after they had sustained a fall.

Rationale and summary
A resident sustained a fall and rang the call bell for assistance. A PSW responded to the call and found that the resident had fallen and proceeded to manually lift the resident on their own. The resident and PSW both stated that the resident was manually lifted after being found post-fall. The PSW stated that residents should not be manually lifted. The ADOC (Assistant Director of Care) stated that, in their internal investigation of the incident, it was established through interviews of the resident and PSW, that the resident had fallen and that the PSW had manually lifted them after they sustained a fall. The ADOC stated manually lifting residents is contrary to the home's Zero-Lift policy.

Risk statement
By manually lifting resident after they had sustained a fall instead of using a mechanical lift, the PSW put the resident at increased risk of injury while being manually lifted.

Sources
Interviews with the resident and PSW involved in the fall, and the ADOC.
Investigation notes completed by the ADOC

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WRITTEN NOTIFICATION: Fall Prevention and Management Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 53 (1) 1.

The licensee has failed to ensure that the Falls Prevention and Management policy was complied with for a resident.

In accordance with O. Reg 246/22, s. 11 (1) (b), the licensee is required to have a falls prevention and management program to reduce the incidence of falls and the risk of injury, and it must be complied with.

Specifically, the PSW (Personal Support Worker) who responded to the fall did not comply with the policy "Falls Prevention and Management", which was included in the licensee's Falls Prevention and Management program.

Rationale and Summary
A resident sustained a fall while in their room. After sustaining the fall, the resident was able to ring their call bell and a PSW responded to the call. The PSW found the resident after they had sustained the fall and elected to immediately transfer the resident back into their bed. Several hours later, the PSW reported the fall to an RPN (Registered Practical Nurse). The resident was later sent to hospital with pain and was diagnosed with an injury.

The resident stated that the PSW who responded to their call bell after they sustained a fall immediately transferred them back to bed. The resident stated they were not assessed by a nurse prior to being transferred. The PSW stated that they moved the resident immediately after discovering the resident had fallen, only informing an RPN of the occurrence several hours after the incident. The PSW also stated that after a resident has sustained a fall, direct care staff must inform nurses immediately to ensure they are assessed by a nurse prior to being transferred. The ADOC (Assistant Director of Care) stated that the PSW should have called for a nurse immediately to ensure the resident was assessed for injury prior to being transferred.

The home's Fall Prevention and Management policy states that care staff, upon discovery of a fallen resident, must report the fall immediately to a nurse. Appendix 5 of the Fall Prevention and Management policy, Post Fall Clinical Pathway, outlines that following a resident's fall, a focused assessment must be performed by a registered nursing staff person and that the clinical decision to move the resident is made by registered staff.

Risk statement
Resident was not assessed immediately post-fall by a member of the Registered Nursing staff. Moving a resident post-fall prior to assessment by a Registered Nursing staff member puts them at risk of sustaining further injury.

Sources
Interviews with the Resident and PSW involved in the incident, the RPN who received the report of the fall, and the ADOC.
Policy RC-15-01-01 Fall Prevention and Management Program
Policy RC-15-01-01 Appendix 5 of the Fall Prevention and Management Program, Post Fall Clinical Pathway
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