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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
May 23, 2019	2019_532590_0014	007050-19	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 Southwood Lakes
1255 North Talbot Road WINDSOR ON N9G 3A4

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

ALICIA MARLATT (590)

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): April 25 and 26, 2019.

During the course of the inspection, the inspector(s) spoke with the Administrator, a Social Worker, one Registered Practical Nurse, one Personal Support Worker, one Clinical Care Coordinator, two contracted caregivers with Home Instead and one family member of a resident.

During the course of the inspection, the inspector(s) reviewed one residents clinical record, meeting minutes, Infoline reports and Critical Incident Systems reports.

During the course of the inspection, the inspector(s) observed residents and their interactions with other residents and staff, observed one residents' room for specific interventions to be in place, infection prevention and control practices and the general cleanliness and maintenance of the home.

The following Inspection Protocols were used during this inspection:
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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007,

c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every resident's right to live in a safe environment was fully respected and promoted.

A complaint was received by the Ministry of Health and Long-Term Care on April 1, 2019, from the Substitute Decision Maker (SDM) for resident #002. They reported that they had concerns about safety in the home and that there was a resident that has been removed by the police on several occasions.

In an interview with resident #002's SDM, they shared that they had witnessed incidents in the hallways where resident #001 was violent and could not be controlled by the staff. They shared that resident #001 had entered resident #002's room when they were present visiting once and resident #001 had grabbed the handles of the wheelchair resident #002 was sitting in and would not let it go. They said that it took several staff members and themselves to escort the resident from their room. They shared that they visited the home daily from about noon to 2200 hours and worry when they go home that resident #001 would hurt their loved one or someone else in the home. They said that resident #002 was impaired and could not protect or defend themselves from an aggressive person attempting to harm them. The SDM said that in speaking with other residents and family members on the unit, they had the same concerns about this resident as they did. They shared that they felt the home was not a safe place because of this resident wandering around.

Review of resident #001's clinical record showed that this resident had impaired cognition. When the resident was admitted to the home they immediately began to display aggressive behaviours towards residents and staff. The behaviours displayed included socially inappropriate actions, wandering into other residents' rooms and was observed to be physically aggressive. The home initiated a specific intervention, to monitor this resident and keep all the residents safe on the unit. Over a two and a half month period, this resident had been removed from the home and taken to the hospital

for further management on four occasions by the police due to being a risk of harm to themselves and others.

Further review of resident #001's clinical record showed that this resident has had several altercations with other residents which has frightened them, however has not caused any injuries. The staff have documented in the progress notes on five separate occasions that resident #001 was a risk of harm to themselves and other residents in the home. The progress notes showed the following entries:

On four separate occasions, resident #001 had wandered into other resident's room and attempted to pull them out of their beds.

On a specific day, staff documented an incident in which resident #001 was removed from the home by police for risk of harm to themselves and others.

On a specific day, resident #001 was attacking the staff and was a risk of harm to themselves and others and could not be managed at the home; the resident had to be isolated and secured in the dining room for safety. The staff had called police and the resident was removed from the home by police and ambulance and was returned to the home the next day.

On a specific day, resident #001 had entered into another resident's room when they were sleeping and hit the resident three times. The staff intervened and covered the resident in bed to protect them from being hit any further. The staff had called the police to come and remove the resident from the home.

In an interview with one to one care provider #104 for resident #001, they shared that the other residents and family members of residents on the same unit were afraid of resident #001.

In an interview with PSW#103 they shared that they were not surprised that someone had called the Ministry with safety concerns about resident #001. They shared that several residents and other family members have approached them with concerns about safety around resident #001 and saying that their loved ones were scared of this resident. They shared that resident #001 displayed behaviours, and often would attempt to wander into other residents' rooms. They shared that this resident put other residents at risk, was not safe here and that they felt this home was not appropriate for this resident. When asked about the behaviours they saw this resident display, they said that

they saw the resident wander around the unit and into other residents rooms, being socially inappropriate and could be physically aggressive. When asked how they managed the behaviours this resident displayed, they shared that when the resident could not be redirected or they couldn't approach the resident, they tried to isolate them to the dining room area, where they could close the fire doors restricting access to other residents and areas where other residents may be, until they calmed down or were removed from the home by police.

In an interview with Registered Practical Nurse #106, they shared that many family members have approached them with their concerns of safety related to resident #001. The RPN was asked about the behaviours displayed and how the staff were directed to manage them. They said that the resident was very confused and was ambulatory. They shared that this resident wandered the halls and into other resident rooms, was physically aggressive and was unpredictable. The resident was difficult to manage and said they have had to call police several times as they were unable to manage the resident.

In an interview with Clinical Care Coordinator #102, they shared that resident #001 often wandered into other residents' rooms and around the unit. The staff were to redirect resident #001 away from other residents and their rooms. If the staff could not redirect the resident away, they would remove the other residents around resident #001 to safe areas and isolate the resident in a safe area where they could de-escalate. They were aware of concerns brought forth by other family members about the safety around resident #001.

In an interview with the Administrator #102 and Social Worker #101, they shared that they were aware of the safety concerns with resident #001. Families and staff members have expressed concerns regarding their safety. They said they have had several workers that have been injured by this resident, and thankfully no residents have been injured up to this point. They shared that they have accessed all the external resources available to them for assistance in managing this resident's care. They shared that the home has followed all the recommendations provided by the external resources, including but not limited to, pharmacological interventions, strategies for effective communication, increased monitoring for behaviour tracking and safety, monitoring of lab values for infections and assessing for pain issues. They shared that the staff have had the resident removed from the home a few times because of the resident's behaviours which were uncontrollable. The home has attempted to advocate for resident #001 in assisting to arrange a more appropriate placement setting, and have had meetings with

people from the Local Health Integration Network (LHIN). The LHIN has refused to assist the home in making more appropriate arrangements for resident #001, until the home has the behaviours under control. The Administrator and Social Worker both acknowledged that resident #001 was a safety risk for themselves and other residents in the home.

The licensee had failed to ensure that every resident's right to live in a safe environment was fully respected and promoted. [s. 3. (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 every resident has the right to live in a safe and clean environment, to be implemented voluntarily.

Issued on this 3rd day of June, 2019

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

Original report signed by the inspector.