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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 29, 2015	2014_247508_0032	H-001505-14	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE ST. CATHARINES
283 Pelham Road St. Catharines ON L2S 1X7

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

ROSEANNE WESTERN (508), ROBIN MACKIE (511)

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): October 27, 28, 29, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, registered staff, Personal Support Workers (PSW), the Social Worker (SW) and residents.

**During the course of this inspection the inspector toured the home, reviewed relevant
policies and procedures and resident clinical records.**

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours**

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

- **2 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	Legendé 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 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 was based on, at a minimum,

interdisciplinary assessment of the following with respect to the resident: 5. Mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

A review of the clinical record for Resident #500 indicated the resident was admitted to the home on an unidentified date in 2014, with identified socially inappropriate behaviours that included inappropriate comments towards staff. Interview with the DOC indicated she became aware of additional, confidential information regarding sexually inappropriate behaviour of the resident that had not been provided on the resident's admission that may have been an identified responsive trigger.

Clinical records indicated that a few months after resident #500 was admitted to the home, resident #502 made an allegation that resident #500 made a request and that they felt uncomfortable. Resident #502 further clarified that they told resident #500 to go away when resident #500 approached them and made the request. Resident #502 complained to their family member/POA who made a written complaint to the administrator of the incident, voiced concerns for the resident's safety and requested resident #500 be moved to another room before the situation escalated into something more serious.

The Administrator confirmed in a reply to the POA that the home was taking actions to resolve the issue and was monitoring the situation very closely. On interview with the Administrator, she clarified that the home's monitoring of the situation was that they were providing extra monitoring of resident #500's behaviours. Resident #500 was moved to another shared room.

A referral to the Niagara Geriatric Mental Health Outreach Program was completed for the behaviour. The referral did not indicate the identified behaviour or the information obtained by the DOC. There was no evidence that resident #500 was provided monitoring as indicated by the Administrator in the letter to the POA. Further review of the clinical record indicated on an unidentified date in 2014, resident #500 had ther behaviour several times and that resident #501 was uncomfortable.

Interviews conducted during this inspection with 4 front line PSW's and one registered staff confirmed they were unaware of any extra monitoring of resident #500's identified behaviours. The written plan of care did not indicate any responsive behaviour or potential triggers for this behaviour. Interview with the Administrator and DOC confirmed resident #500's responsive behaviours, potential behavioural triggers were not in the resident's plan of care. [s. 26. (3) 5.]

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 plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to a resident: 5. Mood and behaviour patterns, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents, including resident #500 and resident #501, by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations.

Resident #500 was admitted into the long-term care facility on an unidentified date in 2014 and shared a room with co-resident #502. A few months later, resident #502, complained to a Personal Support Worker (PSW), that they were uncomfortable with resident #500. The PSW stated during an interview with the Inspector, that she had intentions to take the resident's complaint to the charge nurse but became distracted and forgot.

Resident #502's family member emailed the Administrator with their concerns about resident #500. The family member also requested in this same email that they wanted resident #502 moved to a different room due to these concerns.

Approximately a week later, resident #500 was transferred into another room with resident #501. During an interview with the Administrator and the Director of Care, they had indicated that they also had knowledge of resident #500's past history of being inappropriate towards others not long after the resident was admitted to the facility.

A few weeks after resident #500 was transferred into a shared room with resident #501, resident #501 reported to registered staff that resident #500 had inappropriate behaviour toward resident #501. Later that night, the police were notified and resident #501 was transferred to another room to separate the residents.

It was confirmed by the Director of Care and the Administrator that they were aware of resident #500's inappropriate behaviours, and at the request of resident #502's family member, transferred resident #500 into resident #501's room.

The Director of Care and the Administrator confirmed that steps were not taken to minimize the risk of altercations and potentially harmful interactions between resident #500 and #501. [s. 54. (a)]

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 steps are taken to minimize the risk of altercations and potentially harmful interactions between residents, including resident #500 and resident #501, by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially triggered such altercations, to be implemented voluntarily.

Issued on this 29th day of May, 2015

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

Original report signed by the inspector.