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 prévue le Loi de 2007 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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 25, 2017;	2017_551526_0007 (A1)	005271-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) 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

Ontario

Ministry of Health and Long-Term Care

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THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been amended due to: Rescinding CO #004 for r. 52(2) due to findings that occurred before previous compliance date of November 30, 2016. This area of non compliance has been issued as a WN.

Issued on this 25 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

THERESA MCMILLAN (526) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): March 8, 9, 10, 13, 15, 16, 17, 20, 21, 22, 23, 24, and 27, 2017.

The following inspections were completed simultaneously during this inspection:

Critical Incident inspections:

029280-16: transfer resulting in injury

029339-16: transfer resulting in injury

030412-16: resident to resident abuse

033597-16: fall with fracture

035482-16: resident to resident abuse

003814-17: fall with injury

Complaint inspections:

031336-16: resident wandering

033560-16: fall with injury

002200-17: allegation of abuse; availability of supplies; reporting to the Director; Responsive Behaviours; Continence Care

006091-17: allegation of abuse

005556-17: improper care, responsive behaviours, lack of supplies

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Program Manager, Social Worker (SW), Quality Risk Management Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), maintenance staff, residents, family council representative, and family members.

During the course of this inspection, inspectors reviewed resident health records, investigative notes, complaints log, policies and procedures, training records, toured the home, and observed residents and care.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dignity, Choice and Privacy

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Minimizing of Restraining

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Training and Orientation

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

- **16 WN(s)**
- **7 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 s. 19. (1)	CO #002	2016_30610a_0019	526
LTCHA, 2007 s. 20. (1)	CO #001	2016_30610a_0019	526

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On a specified day in 2017, resident #021 was observed ambulating in the home. Registered staff #122 observed the resident and identified that the plan of care for safe ambulation was not in place. The resident refused any offers for assistance. Registered staff #122 stayed with resident #021 and directed a PSW (Personal Support Worker) to get the resident's ambulation device. After observing resident #021 become at risk for falls, registered staff #022 and the PSW implemented the ambulation plan of care even though the resident stated that they did not want this. It was confirmed during interviews with staff #122, #127 and through review of the resident's clinical record that the resident was not given an opportunity to participate fully in the development and the implementation of the resident's plan of care.

PLEASE NOTE: This area of non-compliance was identified during a complaint inspection, log #006091-17, inspected concurrently during this Resident Quality Inspection (RQI). [s. 6. (5)]

2. The license failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

According to their health records resident #001 was at risk for falls. On a specified day in 2016, they fell and were assessed by registered staff. According to progress notes, later that same day their condition changed. Registered Nurse (RN) #105 paged the attending physician to inform them of this change. The physician did not respond to the page; RN #105 did not follow up prior to the RN leaving their shift and did not ensure that resident #001 was assessed by a physician or NP or that the plan of care was updated.

RN #106 identified that the resident's condition had deteriorated. The physician was contacted and the resident was sent to hospital where they received treatment. In addition, review of the health record indicated that the resident did not receive interventions as needed to address pain associated with their change in condition.

During interview, the Director of Care (DOC) stated that RN #105 should have taken further action such as calling the physician again, the home's medical advisor or the Nurse Practitioner (NP), if a physician had not contacted the home within one hour of a call/page. They confirmed that staff failed to ensure that resident #001 was reassessed when their care needs changed so that the plan of care could be updated.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #033597-16 and Complaint Inspection #033560-16, that were conducted concurrently with the RQI Inspection. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, in accordance with O. Reg. 79/10, s. 221 (2) that required retraining be completed annually.

A) Responsive Behaviours: Review of the home's 2016 training records for the home's Responsive Behaviours Program revealed that 50 out of approximately 80 (62.5%) Personal Support Workers (PSWs) 19 out of 22 (86.4%) registered staff had been trained for responsive behaviours. During interview, the home's Quality Risk Management Coordinator who was responsible for education stated that staff who completed the 2016 staff satisfaction survey during October 2016, identified that they needed/wanted additional training for the management of residents with aggressive behaviours. They confirmed that not all staff in the home had received

training in 2016 for responsive behaviours according to legislative requirements.

B) Restraints: During the course of this inspection, LTC inspectors observed residents #001 and #005 seated in wheelchairs with lap belts that were positioned loosely. Personal Support Workers (PSWs) #101, #103, and #104, 107 were unable to clearly indicate how the lap belts should be applied according to manufacturer's instructions. PSWs #101 and #107 were unable to identify steps to take when conducting a safety check.

Review of the home's 2016 staff retraining for safe application and monitoring of resident with restraints indicated that 30 out of 84 (35.7%) PSWs and 20 out of 22 registered staff (90.9%) had received the training either online or in person. During interview, the home's Quality Risk Management Coordinator (staff #116) stated that the training did not consistently include how to apply lap belts according to manufacturer's instructions, how the lap belts should be used, potential dangers of the lap belts, or what staff should look for during safety checks. Staff #116 confirmed that the home had not met legislative requirements in relation to staff retraining for restraints education in 2016.

C) Safe Lifts and Transfers under Falls Prevention: Review of the home's "Fall Prevention and Management Program" policy number RC-06-04-01 last updated May 2016, Appendix 1.2,(Ways to Reduce Fall Risk – Tip Sheet for Staff) directed staff to always follow safe resident handling procedures (e.g., right devices/equipment, correct positioning and transfer techniques). The policy indicated that staff were to be educated on fall and injury prevention and relevant falls and safe lifting with care program components. During interview, the Quality Risk Management Coordinator stated that the home's lifts and transfers policies were to fall under the umbrella of the home's Falls Management Program and Restorative Program.

Review of the home's training records for safe lifts and transfers revealed that 54/80 (67.5%) PSW staff had received lifts and transfers training in 2016. In addition, 12 out of 22 (45.4%) registered staff received training in the form or review of the home's policy during their professional practice meeting on October 5, 2016. The Quality Risk Management Coordinator confirmed that not all direct care staff in the home had received their Safe Lifts and Transfers using mechanical lifts retraining in 2016. [s. 76. (7)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #007's health records identified their transfer and positioning requirements and plan of care. On a specified day in 2016, the resident's transfer needs were reassessed by the home's Restorative Care Aide #127, the transfer plan of care was updated and the home's policy was implemented in order to notify Personal Support Worker (PSW) staff of the change. The home's "Mechanical Lifts" procedure number 01-03 last updated September 2010 directed staff to use two people to apply and transfer residents using mechanical lifts.

According to progress notes, the home's investigative notes, and interview with PSW #103, PSWs #103 and #124 entered resident #007's room and prepared to assist the resident to bed. While assisting the resident to bed, PSW #103 was not aware of a change in the transfer plan of care and did not follow the home' s safe lifts and transfers policy. The resident fell while being assisted by PSW #103 and sustained an injury for which they required treatment.

During interviews, the home's Director of Care (DOC) and Restorative Care Aide #127 indicated that the transfer of resident #007 was unsafe, did not comply with the home's policy that required two staff to assist resident #007.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #29339-16 that were conducted concurrently with the RQI Inspection. [s. 36.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During interview, the Director of Care (DOC) and the Resident Assessment Inventory (RAI) Coordinator stated that when a resident had pain not relieved by initial interventions and when their pain rated four (4) or greater out of a scale of ten (10), staff were expected to document pain assessments using an instrument designed for that purpose in the assessment tab of the home's electronic documentation system (PCC).

A) Review of the assessment tab indicated that, on a specified day, resident #001's pain was not assessed using a clinically appropriate assessment instrument specifically designed for this purpose and they were not administered medication when they were noted to be having pain. Progress notes indicated that the resident was having pain. Registered staff #106 assessed the resident contacted the physician, and the resident was transferred out of the home for treatment.

During interview, the DOC confirmed that resident #001's pain had not been assessed using a clinically appropriate assessment instrument specifically designed for this purpose when the resident complained of pain.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #033597-16 and Complaint Inspection #033560-16, that were conducted concurrently with the RQI Inspection.

B) According to their health record, resident #007 fell on a specified day in 2016.

They were transferred out of the home for treatment. Upon their return, they were prescribed regularly scheduled and "as needed" (PRN) pain medication. Review of the health record indicated that they complained of pain that was not relieved by initial interventions, where they were not assessed using a clinically appropriate assessment instrument specifically designed for this purpose, on four occasions over a five day period.

During interview, the Director of Care (DOC) and the Resident Assessment Inventory (RAI) Coordinator confirmed that when resident #007's pain was not relieved by initial interventions, they were not assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #029339-16, that was conducted concurrently with the RQI Inspection. [s. 52. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been rescinded:CO# 004

WN #5: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

During the evening on a specified day in 2016, staff responded to a bed alarm going off in resident #011's room. Staff entered the resident's room and witnessed resident #010 standing over resident #011. Resident #011 reported to the staff at the time of the incident that resident #010 touched them and indicated that they were scared. Resident #010 had known responsive behaviours toward co-residents. Interventions had been implemented to increase the monitoring of resident #010; however, this intervention was only in place during the day and not in the evening.

It was confirmed through documentation and during an interview with the Social Worker, that resident #011 was not protected from abuse by anyone.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident (CI) inspection, log #035482-16, conducted concurrently during this Resident Quality Inspection (RQI). [s. 19. (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 protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, that they had been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) According to their health record, on a specified day in 2016, resident #007 fell. They were injured and transferred out of the home for treatment. During interview, the DOC indicated that staff were expected to conduct a post fall assessment using a clinically appropriate assessment instrument found in the home's electronic documentation system. Review of the health record revealed that staff failed to conduct a post fall assessment of resident #007 according to the home's expectation. This was confirmed by the Director of Care (DOC) and the RAI Coordinator.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #029339-16, that was conducted concurrently with the RQI Inspection. (526)

B) On a specified day in 2017, resident #015 was discovered by staff after having an unwitnessed fall. A review of the resident's clinical record indicated that a post-fall assessment had been initiated by the registered staff but not completed. This post fall assessment only had the resident's vital signs documented. A fall risk assessment had been completed the following day, where this resident had been identified as a high risk for falls.

It was confirmed by the RAI-Coordinator, that when the resident had fallen, a post fall assessment using a clinically appropriate assessment instrument that was specifically designed for falls was not conducted.

PLEASE NOTE: This area non-compliance was identified during a complaint inspection, log #002200-17, conducted concurrently during this Resident Quality Inspection (RQI). (508) [s. 49. (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, when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

During this inspection, resident #004 was observed by the Long Term Care Homes (LTC) Inspector having a strong urine odor present. The resident confirmed that they would not be changed due to a lack of continence supplies. During interview, resident #021 indicated that continence care products were not consistently available.They stated that there had been occasions where they had been informed by PSW staff that they had run out of the type of product the resident required and would give them another type of product; they stated that the product offered would not keep them dry.

During interviews conducted with PSW staff and with the DOC, it was revealed that there were sufficient supplies available in the home; however, when staff ran out of the supplies on their unit, not all PSW staff were clear that they had access to the additional supplies stored in another area of the home. Residents confirmed that they had been told by PSW staff at times that they were out of continence supplies or did not have time to re-stock their continence supplies.

This information was confirmed during interviews conducted with staff, residents and with the DOC during the course of this inspection.

PLEASE NOTE: This non-compliance was identified during complaint inspections, log #002200-17 and log #005556-17, conducted concurrently during this RQI. [s. 51. (2) (g)]

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, (g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (2) The licensee shall ensure that, for all programs and services, the matters referred to in subsection (1) are,
(a) integrated into the care that is provided to all residents; O. Reg. 79/10, s. 53 (2).
(b) based on the assessed needs of residents with responsive behaviours; and O. Reg. 79/10, s. 53 (2).
(c) co-ordinated and implemented on an interdisciplinary basis. O. Reg. 79/10, s. 53 (2).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for all programs and services, the matters referred to in subsection (1) which included the development of resident monitoring and internal reporting protocols were, (a) integrated into the care that was provided to all residents.

An interview with the family member of resident #012 indicated that the resident became upset and agitated when co-residents demonstrated certain behaviours and that these behaviours were ongoing. An interview with the DOC, Program Manager and the RAI Coordinator, confirmed that resident #022 demonstrated this known responsive behaviour since their admission and that it affected resident #012 on many occasions over the past year which resulted in resident #012 becoming upset and agitated.

A review of the home's policy, titled, Responsive Behaviours (09-05-01 and dated September 2010) indicated the following:

i) If responsive behaviour is observed, a more in-depth assessment of the behaviour will be undertaken using any one or combination of the following assessment processes/tools:
a. Dementia Observation Scale
b. Cohen Mansfield Agitation Inventory
c. Responsive Behaviour Record
d. Tool used by the local psychogeriatric outreach/support program.

ii) In homes with Point of Care documentation tablets, tasks focusing on reporting observed behaviours are to be added to a resident file as soon as the behaviour was observed. For homes without Point of Care, the Responsive Behaviour Record or the Dementia Observation Scale form was to be used by care staff to record behavioural observations. The determination of what tools to be used should be based on the type of behaviour being assessed and the level of detail required to establish patterns to the behaviour and interventions.

A review of resident #022's clinical record indicated that no assessment tools including the Dementia Observation Scale (DOS) or the Cohen Mansfield Agitation Inventory were able to be located. The DOC confirmed that the home used the Point of Care (POC) documentation tablets. A review of resident #022's tasks in POC indicated that a task for the known behaviour was in place. The RAI Coordinator was able to produce records for time periods where resident #012's family member stated that resident #022's behaviours were present. A review of the behaviour task for these time periods indicated that no records were found.

An interview with the DOC confirmed that the home's developed monitoring and internal reporting protocols had not been integrated into the care that was provided to resident #022 in relation to their responsive behaviour that was known to upset

resident #012.

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #031336-16, that was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 53. (2) (a)]

2. The licensee failed to ensure that for each resident demonstrating responsive behaviours, that actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

An interview with the family member of resident #012 indicated that the resident became upset and agitated when co-residents demonstrated certain behaviours and that these behaviours were ongoing. An interview with the DOC, Program Manager and the RAI Coordinator, confirmed that resident #022 demonstrated this known responsive behaviour since their admission and that it affected resident #012 on many occasions over the past year which resulted in resident #012 to become upset and agitated.

A review of resident #012's clinical record over a 12 month time period, and resident #022's clinical record over an 11 month time period, revealed that one incident was documented where resident #022 exhibited the behaviour known to upset resident #012 and resulted in an altercation between the two residents. No documentation was included regarding what actions were taken to respond to the needs of both resident's or the response of either resident to any interventions that were implemented as a result of this altercation.

An interview with the DOC confirmed that documentation had not been completed for the incident described above, or any other incidents that had occurred over the past year with regards to actions taken to respond to the needs of resident #012 and #022 or the response of both resident's to any interventions that were implemented.

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #031336-16, that was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 53. (4) (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, for all programs and services, the matters referred to in subsection (1) are, (a) integrated into the care that is provided to all residents, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response had been made to the person who made the complaint, indicating:
i. what the licensee had done to resolve the complaint, or
ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

During interview with LTC Inspector #214, resident #003 complained about an incident that involved their personal belongings and a staff yelling at them, that occurred the day before. The incident was reported to the DOC on a specified day during this inspection. Twelve days after this, the DOC reported that their investigation was complete and that the complaint was unfounded. They reported that they had not interviewed the resident, and that they had not provided a response to resident #003 following the complaint investigation. The Social Worker reported during interview that they had spoken with the resident about another matter and stated that they were not aware of this issue. During interview, the resident reported that they were upset by the incident, and did not feel that it was resolved since they had not heard from anyone since they initially reported it to the LTC Inspector. During interview, the DOC confirmed that they had not provided a response to resident #003 following their complaint. [s. 101. (1) 3.]

2. The licensee failed to ensure that a documented record was kept in the home of a complaint not resolved in 24 hours that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A) During interview with LTC Inspector #214, resident #003 complained about an incident that involved their personal belongings and a staff yelling at them, that occurred the day before. The incident was reported to the DOC on a specified day

during this inspection. Twelve days later, the DOC reported that their investigation was complete and that the complaint was unfounded. They reported that the issue was not resolved within 24 hours and that they had not maintained a documented record of the investigation according to legislative requirements.

B) During an interview with resident #014, they verbalized complaints regarding their care and confirmed that they had not brought their complaints to the home's attention. The Long Term Care Homes (LTCH) Inspector informed the DOC of the resident's verbal complaints on the date they were received.

A review of the home's Complaint's Binder that occurred 12 days later indicated that a documented record that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant, had not been documented.

An interview with the DOC confirmed that they had met with the resident the same day they received their complaint to discuss the nature of their verbal complaint but that actions taken to the resolve their complaint were in progress. The DOC confirmed that a documented record that included the required actions listed, had not been initiated. (214)

C) During an interview a family member of resident #012 indicated that they had verbalized complaints to the DOC on more than one occasion regarding the care of the resident in relation to responsive behaviours of an identified co-resident. The family member indicated that they had verbalized these concerns during a specified month in 2016.

A review of the home's Complaint's Binder during this inspection, indicated that a documented record that included the nature of this verbal complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response and any response made in turn by the complainant, had not been documented.

An interview with the DOC confirmed that they had met with the family member of

resident #012 to discuss the nature of their verbal complaint around the identified month in 2016. The DOC confirmed that a documented record that included the required actions listed, had not been initiated by the home.

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #031336-16, that was conducted concurrently with the RQI Inspection. (214) [s. 101. (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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief; and that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

Review of the home's manufacturer's instructions "Pelvic Support Belt: Installation

and User's Instructions" for the use of lap belts in the home directed staff that "This pelvic support belt must be worn tightly fitted across the lower pelvis or thighs at all times. A loose belt can allow the user to slip down and create a risk of strangulation. Have your seating specialist demonstrate its proper adjustment and use....Accidental release of this pelvic support belt can allow the user to slip down or fall from the wheelchair. If the user's movements or cognitive abilities could lead to accidental release, a caregiver must be present at all times during its use.....when properly adjusted and belt tightened, it should fit snug so that the user's pelvis is secure."

A) It was observed on a specified day during this inspection, that resident #005 had a front fastening seat belt applied. The Long Term Care Homes (LTC) Inspector observed that the seat belt was loose and the belt was twisted. The resident was unable to release themselves from the lap belt. The LTC Inspector was able to fit a closed fist in between the resident's abdomen and the belt.

Staff #109 was alerted by the LTC Inspector and tightened the resident's seat belt. It was confirmed through observation and by staff #109 that the physical device was not applied according to the manufacturer's instructions.

B) Resident #005 had a health condition that placed their safety at risk while sitting in a wheelchair with a lap belt applied. On a second specified day during this inspection, the resident was observed by LTC inspector #526 sitting in their wheelchair with the lap belt greater than seven centimetres (7 cm) from the resident's torso. When asked, the resident demonstrated that they were unable to release the lap belt and said that they couldn't.

During interview, PSW #103 confirmed that resident #005's lap belt was too loose and should have been positioned to within two finger widths from the torso. The PSW unfastened the belt and stated that they were having difficulty adjusting it since it was twisted. After untwisting and adjusting it to within two finger widths, they demonstrated that the belt slipped easily through the buckle and became loosened again. The PSW confirmed that the resident's movements and the way the belt was fed through the buckle caused the lap belt to loosen and that it wouldn't stay tightened; they confirmed that they did not know how to fix it. PSW's #103 and #104 confirmed that they were not familiar with the manufacturer's instructions on how the lap belt should be applied.

Three days later, the resident's lap belt was observed to be twisted while the

buckle was fastened with the resident sitting in their wheelchair. This was reported to the DOC who confirmed that the belt was in poor repair and a new belt had been ordered since they went to inspect it after being notified by the LTC Inspector. They confirmed that a lap belt applied loosely and/or twisted was not applied according to the manufacturer's instructions.

C) According to their health record, resident #001 had a lap belt applied. During observation on a specified day during this inspection, the resident was observed sitting in their wheelchair with the lap belt greater than seven centimetres (7 cm) from the resident's torso. During interview, the resident demonstrated and reported that they couldn't unfasten the lap belt.

During interview, RN #100 confirmed that resident #001's lap belt was too loose and should have been positioned at two (2) finger widths, approximately three centimetres (3 cm), and then adjusted the lap belt to this position. PSW #101, who was caring for resident #001 at that time, reported that they had quickly checked the resident about one hour earlier, and required prompting by the Long Term Care (LTC) Inspector, RN #100 and PSW #102 to identify how to apply resident #001's lap belt according to manufacturer's instructions. During interview, the Director of Care (DOC) confirmed that resident #001's lap belt was not applied according to the manufacturer's instructions when it was not worn tightly fitted, and positioned greater than two finger widths from the resident's torso. [s. 110. (1) 1.]

2. The licensee failed to ensure that a physical device used to restrain resident #005 was well maintained.

According to the home's "Physical Restraint Monitoring" number RESI-10-01-04 version November 2012, staff were directed to "Observe and report any issues related to a physical restraint use".

During observation on a specified day during this inspection, resident #005's lap belt was noted to be positioned approximately seven centimetres (cm) from the resident's torso. After being questioned about the lap belt's positioning, Personal Support Worker #103 confirmed that it was loose, twisted, and would become repeatedly loose with the resident's movement. They confirmed that resident #005's movements and the malfunctioning lap belt placed the resident at risk for injury. Three days later resident #005's lap belt was observed to be twisted while it was applied to resident #005. The DOC was informed by the LTC Inspector.

Interview with RN #100 and the DOC confirmed that when staff have identified a lap belt that is in poor repair or not functioning properly, they should notify the registered staff/restorative staff and make a requisition to have the chair repaired; the vendor was coming to the home weekly to make repairs. Interview with restorative staff #108 revealed that resident #005's wheelchair had not been identified as needing service. The DOC reported that after they inspected resident #005's lap belt, they noted that it was twisted and in poor repair, and requisitioned the vendor to come to the home to replace it. They confirmed that staff had not followed the home's policy when they did not report issues or problems related to resident #005's lap belt between March 13 and 15, 2017 to ensure that the lap belt as a restraint was well maintained. [s. 110. (1) 2.]

3. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented to include: The person who applied the device and the time of application; all assessment, reassessment and monitoring, including the resident's response; every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Residents #001 and #005 were observed with lap belts applied loosely. During interviews, PSWs #102, #103, #104, #110, #112 and #113, confirmed that the resident should be monitored for safety hourly and released and repositioned every two hours. PSWs #110, #112, and #113 confirmed that they document these tasks using the home's "Point of Care" (POC) documentation system. Residents #001 and #005's POC documentation over a two week time period, was reviewed for: the person who applied the device and the time of application, hourly monitoring, including the resident's response, every release of the device and all repositioning, the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care for lap belts applied to residents #001 and #005. The documentation was incomplete as follows:

i) Documentation in relation to the use of a lap belt restraint for resident #001 was not completed during the day shift on six occasions.

ii) Documentation in relation to the use of a lap belt restraint for resident #005 was not completed during the day shift on three occasions.

Documentation that was complete revealed that staff documented the application, removal, hourly safety checks and release/repositioning at the same one or two

times for one to seven care occasions during each shift. The documentation did not indicate the time the lap restraint was applied or removed or the post restraining care provided. Interview with the DOC and Resident Assessment Instrument (RAI) Coordinator confirmed that staff had been documenting once or twice during their shift and not at the point of care as required by the home's policy for residents in the home including residents #001 and #005. The RAI Coordinator confirmed documentation that was not completed or did not indicate the time of application and release of a restraint did not comply with legislative requirements for documenting the use of lap belt restraints for residents #001 and #005. [s. 110. (7)]

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 following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act: 1. Staff apply the physical device in accordance with any manufacturer's instructions; that he physical device is well maintained; and that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: 5. The person who applied the device and the time of application. 6. All assessment, reassessment and monitoring, including the resident's response. 7. Every release of the device and all repositioning. 8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

According to their health record, resident #007 fell on a specified day in 2016. They were injured and were transferred out of the home for treatment. Review of their health record indicated that they had regularly scheduled and "as needed" (PRN) medication prescribed. Progress notes indicated that when their condition changed on a specified day in 2016, new physician orders for regularly scheduled and PRN medication were received. The change in medication administration was not initiated until the following day even though the resident continued to have symptoms for which the medication had been prescribed.

Review of the health record indicated that they complained about symptoms that were not relieved by initial interventions, and where they were not administered medication as prescribed on seven occasions over an eight day period.

During interview, the Director of Care (DOC) and the Resident Assessment Instrument (RAI) Coordinator confirmed that when resident #007's symptoms were not relieved by initial interventions, medication was not administered in accordance with the directions for use as specified by the prescriber.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #029339-16, that was conducted concurrently with the RQI Inspection. [s. 131. (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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked, ii.equipped with a door access control system that is kept on at all times.

During a tour of the home an exit door at the end of the first floor, north resident hallway was observed to be unlocked. The Long Term Care Homes (LTCH) Inspector was able to open this exit door and observed a stairwell as well as another exit door which was able to be opened and lead into the home's parking lot. The exit door on the unit was observed to be equipped with a door access control system and a key switch panel.

An interview with maintenance staff #136 confirmed that the key switch had not been activated to set the access control system into the working position and as a result the exit door was not locked. Staff #136 confirmed that this exit door was to be locked and the door access control system was to be kept on at all times. [s. 9. (1)]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected, or witnessed incident that the licensee knew of, or that was reported, was immediately investigated that included abuse of a resident by anyone.

Review of resident #003's progress notes indicated that on a specified day in 2017, they reported possible financial abuse to the home's Social Worker (SW). One month later, the resident told the SW about another concern relating to financial abuse and stated that they did not want the police involved.

During interview, the SW described three conversations over a one month time frame with resident #003 where the resident had stated that they were worried about what may have been financial abuse. The SW indicated that they were not sure if the resident's money had been misused or misappropriated and that they did not contact the resident's SDM or initiated an investigation. The SW confirmed that they did not immediately investigate an allegation of financial abuse after their interviews with resident #003 over a one month time period. [s. 23. (1) (a)]

WN #14: 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:
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 7. Physical functioning, and the type and level of assistance that was required related to activities of daily living, including hygiene and grooming.

A Critical Incident System (CIS) submitted by the home indicated that on a specified day in 2016, resident #006 sustained an injury of an unknown cause during transferring that resulted in a significant change in the resident's health status. A review of the resident's written plan of care revealed that the transferring care area was revised following this change in health status. A review of the resident's assessments in Point Click Care (PCC) indicated that a transfer assessment had not been completed.

An interview with the DOC confirmed that the home was to complete a "Resident Lift and Transfer Assessment" in PCC and that one had not been completed when the resident's plan of care was revised. The DOC confirmed that the care set out in resident #006's plan of care in relation to their transfer needs, had not been based on an assessment of the resident's needs and preferences.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #029280-16, that was conducted concurrently with the RQI Inspection. (Inspector #214) [s. 26. (3) 7.]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During an interview with resident #021, they indicated that they were scheduled to have a bath that day; however, it was not provided. The resident also stated that the staff were working short that day and that this had happened several times before over the past several weeks.

A review of the resident's clinical record over a one month time frame in 2017, revealed that the resident only received five out of the eight baths. During an interview the Director of Care (DOC) indicated that residents that do not receive their scheduled baths due to staffing shortages, are to be offered a bath on another shift or the following day. The resident had not been offered another bath when these baths were missed.

It was confirmed though documentation and during an interview with the resident that the resident had not been bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee failed to ensure that procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

An interview with the family member of resident #012 indicated that the resident became upset and agitated when co-residents demonstrated certain behaviours and that these behaviours were ongoing. An interview with the DOC, Program Manager and the RAI Coordinator, confirmed that resident #022 demonstrated this known responsive behaviour since their admission and that it affected resident #012 on many occasions over the past year which resulted in resident #012 to become upset and agitated.

A review of resident #012's clinical record over a 12 month time period, and resident #022's clinical record over an 11 month time period, revealed that one incident was documented where resident #022 exhibited the behaviour known to upset resident #012 and resulted in an altercation between the two residents. A review of resident #012's written care plan and confirmed with the DOC, identified that interventions to assist resident #012, who was at risk for harm as well as to minimize the risk of altercations and potentially harmful interactions between resident #012 and #022, had not been created until nine months after the incident described above.

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection #031336-16, that was conducted concurrently with the RQI Inspection. [s. 55. (a)]

Issued on this 25 day of May 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

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119 King Street West, 11th Floor
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : THERESA MCMILLAN (526) - (A1)

Inspection No. / No de l'inspection : 2017_551526_0007 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 005271-17 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 25, 2017;(A1)

Licensee / Titulaire de permis :
EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD :
EXTENDICARE ST. CATHARINES
283 Pelham Road, St. Catharines, ON, L2S-1X7

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Jane Freeman

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

When a resident has fallen and they demonstrate pain and/or an identified injury/change in care needs, the licensee shall do the following:
1) Inform a Physician or Nurse Practitioner (NP) of these changes in care needs;
2) Contact the Physician or NP again within 1 hour of an unanswered page;
3) Take steps to ensure that the resident is reassessed including sending the resident to hospital; and
4) Contact the substitute decision maker (SDM) as applicable.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (3), scope (3) and Compliance history of (4) in keeping with r. 229 of the Regulation. This is in respect to the severity of actual harm/risk that the identified residents experienced, the scope of widespread of incidents and the home's history of noncompliance that included the following: a VPC issued October 2016, CO on August 2015, and VPC on September 2014.

2. The license failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

According to their health records resident #001 was at risk for falls. On a specified day in 2016, they fell and were assessed by registered staff. According to progress notes, later that same day their condition changed. Registered Nurse (RN) #105 paged the attending physician to inform them of this change. The physician did not respond to the page; RN #105 did not follow up prior to the RN leaving their shift and did not ensure that resident #001 was assessed by a physician or NP or that the plan of care was updated.

RN #106 identified that the resident's condition had deteriorated. The physician was contacted and the resident was sent to hospital where they received treatment. In addition, review of the health record indicated that the resident did not receive interventions as needed to address pain associated with their change in condition.

During interview, the Director of Care (DOC) stated that RN #105 should have taken further action such as calling the physician again, the home's medical advisor or the Nurse Practitioner (NP), if a physician had not contacted the home within one hour of a call/page. They confirmed that staff failed to ensure that resident #001 was reassessed when their care needs changed so that the plan of care could be updated.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #033597-16 and Complaint Inspection #033560-16, that were conducted concurrently with the RQI Inspection. (526)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Jun 02, 2017

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:

1. Abuse recognition and prevention.
2. Mental health issues, including caring for persons with dementia.
3. Behaviour management.
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations.
5. Palliative care.
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Order / Ordre :

The licensee shall retrain all direct care staff in the following areas:

1) Responsive Behaviours Program including but not limited to:
i) The integration of program components into the care that is provided to all residents;
ii) The documentation of all actions taken to respond to the needs of residents demonstrating responsive behaviours and the resident's response to these actions; and
iii) The development and implementation of procedures and interventions to minimize the risk of altercations between residents and to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours.

2) Restraints: including but not limited to:
i) The application of restraints according to manufacturer's instructions;
ii) The (safety) monitoring and repositioning of resident with restraints;
iii) The documentation of care provided according to legislative requirements and the home's policy; and
iv) The implementation of the home's policy if a restraint can not be applied according to manufacturers' instructions.

3) Lifts and Transfers: including but not limited to
i) The application of lifts and transfers according to manufacturer's instructions
ii) Awareness of a resident's transfer and lift plan of care; and
iii) The home's Lifts and Transfers policy.

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (2), scope (2) and Compliance history of (3) in keeping with r. 299 of the Regulation. This is in respect to the severity of potential for actual harm that identified residents experienced, the scope of pattern of incidents and the home's history of noncompliance that included the following: A VPC was issued August, 2015.

2. The licensee failed to ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, in accordance with O. Reg. 79/10, s. 221

(2) that required retraining be completed annually.

A) Responsive Behaviours: Review of the home's 2016 training records for the home's Responsive Behaviours Program revealed that 50 out of approximately 80 (62.5%) Personal Support Workers (PSWs) 19 out of 22 (86.4%) registered staff had been trained for responsive behaviours. During interview, the home's Quality Risk Management Coordinator who was responsible for education stated that staff who completed the 2016 staff satisfaction survey during October 2016, identified that they needed/wanted additional training for the management of residents with aggressive behaviours. They confirmed that not all staff in the home had received training in 2016 for responsive behaviours according to legislative requirements.

B) Restraints: During the course of this inspection, LTC inspectors observed residents #001 and #005 seated in wheelchairs with lap belts that were positioned loosely. Personal Support Workers (PSWs) #101, #103, and #104, 107 were unable to clearly indicate how the lap belts should be applied according to manufacturer's instructions. PSWs #101 and #107 were unable to identify steps to take when conducting a safety check.

Review of the home's 2016 staff retraining for safe application and monitoring of resident with restraints indicated that 30 out of 84 (35.7%) PSWs and 20 out of 22 registered staff (90.9%) had received the training either online or in person. During interview, the home's Quality Risk Management Coordinator (staff #116) stated that the training did not consistently include how to apply lap belts according to manufacturer's instructions, how the lap belts should be used, potential dangers of the lap belts, or what staff should look for during safety checks. Staff #116 confirmed that the home had not met legislative requirements in relation to staff retraining for restraints education in 2016.

C) Safe Lifts and Transfers under Falls Prevention: Review of the home's "Fall Prevention and Management Program" policy number RC-06-04-01 last updated May 2016, Appendix 1.2,(Ways to Reduce Fall Risk – Tip Sheet for Staff) directed staff to always follow safe resident handling procedures (e.g., right devices/equipment, correct positioning and transfer techniques). The policy indicated that staff were to be educated on fall and injury prevention and relevant falls and safe lifting with care program components. During interview, the Quality Risk Management Coordinator stated that the home's lifts and transfers policies were to fall under the umbrella of the home's Falls Management Program and Restorative

Program.

Review of the home's training records for safe lifts and transfers revealed that 54/80 (67.5%) PSW staff had received lifts and transfers training in 2016. In addition, 12 out of 22 (45.4%) registered staff received training in the form or review of the home's policy during their professional practice meeting on October 5, 2016. The Quality Risk Management Coordinator confirmed that not all direct care staff in the home had received their Safe Lifts and Transfers using mechanical lifts retraining in 2016. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Aug 11, 2017

Order # /
Ordre no : 003

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

The licensee shall do the following:
1) Use safe transferring and positioning devices and/or techniques when assisting residents.
2) Conduct and document audits on transferring techniques used by staff with residents that may include
i) Monitoring that the resident's transfer status is based on an assessment;
ii) Monitoring that the resident's logo is up to date;
iii) That staff are aware of the resident's transfer status,
iv) That staff apply and use the lift according to manufacturer's instructions and the home's policy.

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. This Order is being issued based on the application of the factors of severity (3), scope (1) and Compliance history of (4) in keeping with r. 299 of the Regulation. This is in respect to the severity of actual harm/risk that the identified resident experienced, the scope of isolated of incidents and the home's history of noncompliance that included the following: VPC was issued on September 28, 2014.

2. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

Resident #007’s health records identified their transfer and positioning requirements and plan of care. On a specified day in 2016, the resident's transfer needs were reassessed by the home's Restorative Care Aide #127, the transfer plan of care was updated and the home's policy was implemented in order to notify Personal Support Worker (PSW) staff of the change. The home's "Mechanical Lifts" procedure number 01-03 last updated September 2010 directed staff to use two people to apply and transfer residents using mechanical lifts.

According to progress notes, the home's investigative notes, and interview with PSW #103, PSWs #103 and #124 entered resident #007's room and prepared to assist the resident to bed. While assisting the resident to bed, PSW #103 was not aware of a change in the transfer plan of care and did not follow the home' s safe lifts and transfers policy. The resident fell while being assisted by PSW #103 and sustained an injury for which they required treatment.

During interviews, the home's Director of Care (DOC) and Restorative Care Aide #127 indicated that the transfer of resident #007 was unsafe, did not comply with the home's policy that required two staff to assist resident #007.

PLEASE NOTE: This non-compliance was issued as a result of a CIS Inspection #29339-16 that were conducted concurrently with the RQI Inspection. (526)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Aug 11, 2017

(A1)
The following Order has been rescinded:

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : THERESA MCMILLAN - (A1)

Service Area Office /
Bureau régional de services : Hamilton