Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 14, 2019	2019_569508_0016	003903-18, 005523-18, 023205-18, 024986-18, 026695-18, 027034-18, 030210-18, 003914-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare St. Catharines
283 Pelham Road St. Catharines ON L2S 1X7

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

ROSEANNE WESTERN (508), CATHY FEDIASH (214), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 21, 22, 25, 26, 27, 28, 29, April 2, 3, 4, 5, 8, 9, 10, 11, 2019.

During the course of the inspection, the inspector(s) toured the facility, observed the provision of care, reviewed resident clinical records, relevant policies and procedures, staff training records, 2018 complaint log, 2018 medication incident reports, 2018 program evaluations and the home's investigative notes.

PLEASE NOTE: This complaint inspection was conducted concurrently with a Critical Incident (CI) inspection, #2019_569508_0015.

The following complaint inspections were conducted during this inspection:

-Log #027034-18 related to an allegation of neglect;
-Log #023205-18 related to skin and wound management;
-Log #026695-18 related to a denial of admission:
-Log #003903-18 related to an allegation of neglect;
-Log #005523-18 related to wrongful discharge;
-Log #024986-18 related to multiple care concerns;
-Log #003914-19 related to a medication error;
-Log #030210-18 related to an allegation of neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Registered Dietitian (RD), Social Worker, Program Manager, Dietary Manager, Quality Improvement and Clinical Care Coordinator, registered staff, Personal Support Workers (PSW)s, residents and family members.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **10 WN(s)**
- **5 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration.

During this complaint inspection, it was identified that resident #001 had an alteration of skin integrity and other identified risks.

On an identified date in 2018, documentation in the resident's clinical record indicated that the resident had a new alteration in their skin integrity on a specific area. A referral had been completed the same day to the home's Wound Care Lead (WCL) for further follow up. Review of the follow up portion of this referral indicated that a follow up had not been done which included a referral to the Registered Dietitian (RD).

Review of the resident's written plan of care indicated that resident #001 had another identified risk. Interventions were implemented and the resident had been ordered an intervention.

During an interview with the Registered Dietitian (RD) it was determined that resident #001 had a specific total intake requirement over a specific period of time based on their

calculations.

An electronic document was reviewed over an identified period of time. Documentation reviewed indicated that the resident did not meet their identified requirements and a referral to the RD had not been completed.

On an identified date later that month, the resident was transferred and admitted to hospital due to identified complications.

It was confirmed during review of the resident's clinical records and during interview with the RD, that the licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration as no assessment and no referral had been completed. [s. 50. (2) (b) (iii)]

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home.

During a complaint inspection, it was identified during a review of the resident's clinical records that resident #201 had a history of altered skin integrity and in 2017, an area of altered skin integrity had re-opened.

A review of the resident's clinical record indicated that a referral had not been completed for a RD assessment when this area had re-opened. During interview with registered staff #111, it was identified that the RD did not assess the resident for the area of altered skin integrity until an identified date in 2018 as a referral had not been completed.

It was confirmed during review of the resident's clinical records and during interview with staff #111 that resident #201 exhibited altered skin integrity and had not been assessed by a registered dietitian when the resident's area of altered skin integrity re-opened. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, when clinically indicated.

During a complaint inspection, it was identified during a review of the resident's clinical records that resident #201 had a history of altered skin integrity and on an identified date in 2017, this area re-opened.

Treatment interventions were implemented and a wound assessment was conducted; however, record review indicated that another wound assessment had not been completed until almost a month later.

On an identified date in 2018, the resident was transferred to hospital and admitted due to identified complications.

It was confirmed during records reviews and during an interview with registered staff #111 that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had not been reassessed at least weekly by a member of the registered nursing staff, when clinically indicated. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the resident who exhibits altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, when clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 resident #001 was not neglected by the licensee or staff.

For the purposes of the Act and Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being of one or more residents.

During this inspection, it was identified that resident #001 had impaired skin integrity and other identified risks.

Complaints were brought forth to the Ministry of Health and Long Term Care (MOHLTC) that resident #001 was not receiving the care that they required.
During review of the resident's clinical records, it was identified that there was a pattern of inaction related to the resident's care.

On an identified date in 2018, registered staff #103 documented that the resident exhibited identified symptoms. Registered staff #103 provided an intervention to alleviate their symptoms; however, two days later, the resident's visitor identified that the resident's condition had worsened and brought it to the staff's attention. It wasn't until this time that an order was received from the physician.

On an identified date in 2018, documentation in the resident's clinical record indicated that the resident had a new alteration in skin integrity on a specific area. A referral had been completed the same day to the home's Wound Care Lead (WCL) for further follow up. Review of the follow up portion of the referral indicated that a follow up had not been done.

During interview with registered staff #104, it was revealed that there was no WCL at the time the referral was submitted and therefore the referral was not reviewed or followed up by anyone. The following weekly wound care assessment indicated that the resident's alteration in skin integrity had deteriorated.

Review of the resident's written plan of care indicated that resident #001 had also been identified with an identified risk. Interventions were implemented.

During an interview with the Registered Dietitian (RD), it was determined that resident #001 had a specific intake requirement over an identified period based on their calculations.

An electronic document was reviewed over an identified period of time. Documentation reviewed indicated that the resident did not meet their identified requirements and a referral to the RD had not been completed.

A review of the home's Food and Fluid Intake Monitoring policy directs nursing staff to complete a Nursing Hydration Assessment if after considering additional fluid intake, the resident still has not met their individualized fluid target for three consecutive days. If the hydration assessment indicates signs and symptoms of dehydration, immediately implement interventions to increase fluid intake based on the needs and preferences of the resident, in collaboration with the Dietary Department Lead.
Refer to the RD/designate if sign or symptoms of dehydration were present. The RD and the Dietary Manager confirmed during interviews that the referrals had not been completed or received by their department.

On an identified date later that month, the resident was transferred to hospital and admitted due to identified complications.

It was confirmed during review of the resident clinical records and during interviews with the Director of Care and the Administrator that the licensee failed to ensure that resident #001 was not neglected by the licensee or staff. [s. 19. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, 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. In accordance with O. Reg. 79/10, s. 221(1) 2, 3, 4 and s. 219(3) the home was required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Care, Continence Care and Bowel Management and Pain Management. The licensee failed to ensure that all staff who provided direct care to residents received the annual training in the area of Skin and Wound Care, Continence Care and Bowel Management and Pain Management.

During the course of this inspection, the Long Term Care Home (LTCH) Inspector requested training records for 2018 in the following areas;
- Skin and Wound Care;
- Continence Care and Bowel Management;
- Pain Management;

It was identified that in 2018, only 65 percent (%) of registered staff and 57% of PSW staff were re-trained in Skin and Wound Care, 73% of registered staff and 50% of PSW staff were re-trained in Pain Management and 46% of registered staff and 50% of PSW staff were re-trained in Continence Care and Bowel Management.

It was confirmed during review of the 2018 training records and during interviews conducted with the Quality Improvement and Clinical Care Coordinator on March 29 and April 8, 2019, that in 2018 not all staff received re-training for Skin and Wound, Pain Management and Continence Care and Bowel Management. [s. 76. (7) 6.]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 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.

During this inspection it was identified that resident #002 had an identified diagnosis and required a specific intervention. It was identified during review of the resident's most current plan of care that it had not been updated when the resident's need for this intervention changed.

It was confirmed during review of the resident's clinical record and during interview with registered staff #104 that the plan of care was not reviewed and revised when the resident's care needs changed. [s. 6. (10) (b)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective.

During this inspection it was identified that resident #003 was a risk for falls in 2018 due to their cognitive status and other identified risks. Interventions were developed and implemented.

A review of the resident's clinical records revealed that the resident had multiple falls in 2018. On an identified date, the resident sustained an injury due to a fall.
It was identified during review of the resident's plan of care that interventions in the resident's plan had not been revised until after numerous falls and the resident sustained an injury.

It was confirmed during review of the resident's clinical records and during interview with registered staff #104 that the licensee failed to ensure the resident was reassessed and the plan of care reviewed and revised when care set out in the plan had not been effective. [s. 6. (10) (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 the resident is reassessed and the plan of care reviewed and revised when care set out in the plan is not effective, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of the long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 68(2), the licensee was required to have a system to monitor and evaluate the food and fluid intake of residents with identified risks relation to nutrition and hydration.

The licensee's policy, Food and Fluid Intake Monitoring, (RC-18-01-01, last reviewed February, 2017) indicated that nursing staff are to complete a Nursing Hydration Assessment if after considering additional fluid intake, the resident still has not met their individualized fluid target for three consecutive days.

If the hydration assessment indicates signs and symptoms of dehydration, immediately implement interventions to increase fluid intake based on the needs and preferences of the resident, in collaboration with the Dietary Department Lead.
Refer to the RD/designate if sign or symptoms of dehydration were present.

Review of the resident's written plan of care indicated that resident #001 had an identified risk.

During an interview with the Registered Dietitian (RD), it was determined that resident #001 had a specific requirement over an identified period of time based on their calculations.

An electronic document was reviewed over an identified period of time. Documentation reviewed indicated that the resident did not meet their identified requirements and a referral to the RD had not been completed.

On an identified date later that month, the resident was transferred and admitted to hospital due to identified complications.

The RD reviewed this document and indicated during interview that they should have received a referral and no referral had been completed.

It was confirmed through record reviews and during interviews that the home's Food and Fluid Monitoring policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

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 where the Act or this Regulation require the licensee of the long-term care home to institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following was complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under sections 48 of this Regulation:
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

During review of the home's Skin Care Quality Program Evaluation for 2018, it was identified that the evaluation had not been completed. The list of the dates of the Quality Skin Care meetings held in the home was blank which would identify if the objectives with

expected outcomes were reviewed and met for the previous year.

During interview with registered staff #104 it was confirmed that theses meetings had not taken place in 2018.

It was confirmed during review of the 2018 Skin Care Program Evaluation and during interview with registered staff #104 that the Skin and Wound Care program had not been updated at least annually. [s. 30. (1) 3.]

2. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

During compliant inspections, log #027034-18 and #030210-18, it was identified during review of the resident's clinical records that resident #002 had a device and required an intervention monthly and when necessary (PRN).

A review of the progress notes and the electronic Treatment Administration Record (e-TAR)s for January and February, 2019, revealed that on a specified date in 2019, the resident's device was managed with an intervention. Eight days later, the device was scheduled to receive this intervention. A signature on the e-TAR on this date was recorded as a '9' which according to the e-TAR legend indicated to see Nurses Notes. No documentation had been completed related to this intervention.

On a specified date in 2019, the physician had documented in the resident's progress notes that the resident's device had been managed with this intervention the night before; however, this intervention had not been documented.

It was confirmed during review of the resident's clinical records and during interview with registered staff #104 that not all actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions had been documented. [s. 30. (2)]

3. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

In February, 2019, resident #005 had a significant change in their condition due to two

diagnoses. This caused a symptom and was affecting their cognition, therefore placing the resident at higher risk for a condition.

During a review of the resident's clinical records; specifically the document titled Total Fluids, Meals/Snacks, between two dates in 2019, revealed that not all of the resident's intake of fluids were being documented. During interview with registered staff #104, the staff confirmed that the resident was consuming their targeted fluid intake; however, the clinical record reviewed indicated that not all of the resident's intake was being documented.

It was confirmed during review of the resident's clinical records and during interview with staff #104 that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented. [s. 30. (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 actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #7: 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.

During this inspection, it was identified that resident #007 had a specific diagnosis and was prescribed a specific intervention. On an identified date in 2019, it was brought to the staff's attention that resident #007 had identified symptoms. The resident was assessed and monitored at the home.

Registered staff #111 documented that they were informed that an error had been made.

The indivicual accidentally administered the wrong dose on three separate occasions. The physician was notified and the resident was transferred to hospital for further assessment. The resident was admitted to hospital for an identified period of time.

It was confirmed during interview with the Director of Care that the licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee failed to ensure that when they withheld approval for admission, the persons described in subsection (10) 1. The applicant. 2. The Director. 3. The appropriate placement co-ordinator, were given written notice that set out, a) the ground or grounds on which the licensee was withholding approval; (b) a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and requirements for care; (c) an explanation of how the supporting facts justified the decision to withhold approval; and (d) contact information for the Director.

A review of a complaint indicated that the Long Term Care (LTC) home had not provided written notice to applicant #010 that had set out the information above, when they withheld the applicant's approval for admission.

During an interview with the Administrator, they provided a document that indicated that the LTC home had provided written notice to the Local Health Integration Network (LHIN) regarding refusal of applicant #010 to the LTC home. The Administrator confirmed that written notice had not been provided to the Director and at the time of this inspection, were unable to locate records that written notice of the applicant's refusal, had been provided to the applicant. [s. 44. (9)]

WN #9: 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 a resident has fallen, the resident was reassessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

During a complaint inspection it was identified that resident #008 had a specific diagnosis and was a risk for falls in 2017 due to cognitive status and other identified risk factors.

The resident's plan of care directed staff to conduct a root cause analysis when the resident had fallen. Review of the resident's clinical records indicated that the resident had an identified number of falls in 2017. During review of the post fall assessments it was revealed that on an identified date the clinically appropriate post fall assessment had not been completed which included a risk review, medication review and the root cause analysis after the resident had fallen.

During interview with registered staff #104 it was confirmed that when the resident had fallen, a post-fall assessment had not been conducted using a clinically appropriate assessment instrument that was specifically designed for falls. [s. 49. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that before discharging a resident under O.Reg.79/10, s.145 (1), they provided a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident.

A review of a complaint indicated that resident #009, had been wrongfully discharged from the Long Term Care (LTC) home.

During an interview with the Administrator and the Resident Program Manager, it was confirmed that resident #009 had been discharged from the LTC home on an identified date in 2018.

The Administrator confirmed that written notice to the resident and the resident's substitute decision-maker (SDM), setting out a detailed explanation of the supporting facts, as they related both to the home and to the resident's condition and requirements for care, that justified the licensee's decision to discharge the resident, had not been provided. [s. 148. (2)]

Issued on this 23rd day of May, 2019

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ROSEANNE WESTERN (508), CATHY FEDIASH (214), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2019_569508_0016
Log No. / No de registre :	003903-18, 005523-18, 023205-18, 024986-18, 026695-18, 027034-18, 030210-18, 003914-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	May 14, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
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

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

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 :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with O. Reg.79/10, r. 50(2)(b).

Specifically, the licensee must:

1. Provide mandatory training to all registered staff on the home's skin and wound policy including the referral process to the Registered Dietitian of the home.

2. Develop and implement an auditing process to ensure that residents with alteration in skin integrity are assessed by a Registered Dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented.

Grounds / Motifs :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration.

During this complaint inspection, it was identified that resident #001 had an alteration of skin integrity and other identified risks.

On an identified date in 2018, documentation in the resident's clinical record indicated that the resident had a new alteration in their skin integrity on a specific area. A referral had been completed the same day to the home's Wound Care Lead (WCL) for further follow up. Review of the follow up portion of this referral indicated that a follow up had not been done which included a referral to the Registered Dietitian (RD).

Review of the resident's written plan of care indicated that resident #001 had another identified risk. Interventions were implemented and the resident had been ordered an intervention.

During an interview with the Registered Dietitian (RD) it was determined that resident #001 had a specific total intake requirement over a specific period of time based on their calculations.

An electronic document was reviewed over an identified period of time. Documentation reviewed indicated that the resident did not meet their identified requirements and a referral to the RD had not been completed.

On an identified date later that month, the resident was transferred and admitted to hospital due to identified complications.

It was confirmed during review of the resident's clinical records and during interview with the RD, that the licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and had changes made to the plan of care related to nutrition and hydration as no assessment and no referral had been completed. [s. 50. (2) (b) (iii)]

(508)

2. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessment by a registered dietitian who was a member of the staff of the home.

During a complaint inspection, it was identified during a review of the resident's clinical records that resident #201 had a history of altered skin integrity and on an identified date in 2017, this area re-opened.

Treatment interventions were implemented and a wound assessment was conducted; however, record review indicated that another wound assessment had not been completed until almost a month later.

On an identified date in 2018, the resident was transferred to hospital and admitted due to identified complications.

It was confirmed during records reviews and during an interview with registered staff #111 that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had not been reassessed at least weekly by a member of the registered nursing staff, when clinically

indicated. [s. 50. (2) (b) (iv)]

The severity of the issue was determined as a level 2 as there was a potential for actual harm, the scope of the issue was a level 2, a pattern, the home had a level 2 as they had on-going unrelated non-compliance. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 19(1) of the LTCH Act, 2007.

Specifically the licensee must:

1. Ensure that all residents are not neglected by the licensee or staff with a change in condition, including but not limited to, infections, alterations in skin integrity and nutrition and hydration risk are assessed and interventions are implemented.

2. Develop and implement an auditing process to ensure that staff are implementing interventions as required to ensure that all residents are receiving treatment, care, services or assistance required for health, safety or well-being.

Grounds / Motifs :

1. The licensee failed to ensure that resident #001 was not neglected by the licensee or staff.

For the purposes of the Act and Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being of one or more residents.

During this inspection, it was identified that resident #001 had impaired skin integrity and other identified risks.

Complaints were brought forth to the Ministry of Health and Long Term Care (MOHLTC) that resident #001 was not receiving the care that they required. During review of the resident's clinical records, it was identified that there was a

pattern of inaction related to the resident's care.

On an identified date in 2018, registered staff #103 documented that the resident exhibited identified symptoms. Registered staff #103 provided an intervention to alleviate their symptoms; however, two days later, the resident's visitor identified that the resident's condition had worsened and brought it to the staff's attention. It wasn't until this time that an order was received from the physician.

On an identified date in 2018, documentation in the resident's clinical record indicated that the resident had a new alteration in skin integrity on a specific area. A referral had been completed the same day to the home's Wound Care Lead (WCL) for further follow up. Review of the follow up portion of the referral indicated that a follow up had not been done.

During interview with registered staff #104, it was revealed that there was no WCL at the time of the referral and therefore the referral was not reviewed or followed up by anyone. The following weekly wound care assessment indicated that the resident's alteration in skin integrity had deteriorated.

Review of the resident's written plan of care indicated that resident #001 had also been identified with an identified risk. Interventions were implemented.

During an interview with the Registered Dietitian (RD), it was determined that resident #001 had a specific intake requirement over an identified period based on their calculations.
An electronic document was reviewed over an identified period of time. Documentation reviewed indicated that the resident did not meet their identified requirements and a referral to the RD had not been completed.

A review of the home's Food and Fluid Intake Monitoring policy directs nursing staff to complete a Nursing Hydration Assessment if after considering additional fluid intake, the resident still has not met their individualized fluid target for three consecutive days. If the hydration assessment indicates signs and symptoms of dehydration, immediately implement interventions to increase fluid intake based on the needs and preferences of the resident, in collaboration with the Dietary Department Lead.

Refer to the RD/designate if sign or symptoms of dehydration were present. The RD and the Dietary Manager confirmed during interviews that the referrals had not been completed or received by their department.

On an identified date later that month, the resident was transferred to hospital and admitted due to identified complications.

It was confirmed during review of the resident clinical records and during interviews with the Director of Care and the Administrator that the licensee failed to ensure that resident #001 was not neglected by the licensee or staff. [s. 19. (1)]

The severity of the issue was a level 3 as there was actual harm/risk to the resident, the scope of the issue was a level 1, isolated. The home had a level 5 history as they had on-going non-compliance with a Voluntary Plan of Correction (VPC) issued on report #2017_551526_0007 on May 11, 2017 and a Compliance Order (CO) issued on report #2016_30610_0019 on October 28, 2016, with a Compliance Due Date (CDD) of November 30, 2016.
(508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 09, 2019

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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 must be compliant with s. 76(7) of the LTCH Act, 2007.

Specifically, the licensee must:

1. Provide mandatory training to all direct care staff on the home's Skin and Wound Care program, Pain Management program, Continence Care and Bowel Management.

Grounds / Motifs :

1. 1. In accordance with O. Reg. 79/10, s. 221(1) 2, 3, 4 and s. 219(3) the home was required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Care, Continence Care and Bowel Management and Pain Management. The licensee failed to ensure that all staff who provided direct care to residents received the annual training in the area of Skin and Wound Care, Continence Care and Bowel Management and Pain Management.

During the course of this inspection, the Long Term Care Home (LTCH) Inspector requested training records for 2018 in the following areas;
- Skin and Wound Care;
- Continence Care and Bowel Management;
- Pain Management;

It was identified that in 2018, only 65 percent (%) of registered staff and 57% of PSW staff were re-trained in Skin and Wound Care, 73% of registered staff and 50% of PSW staff were re-trained in Pain Management and 46% of registered staff and 50% of PSW staff were re-trained in Continence Care and Bowel Management.

It was confirmed during review of the 2018 training records and during interviews conducted with the Quality Improvement and Clinical Care Coordinator on March 29 and April 8, 2019, that in 2018 not all staff received re-training for Skin and Wound, Pain Management and Continence Care and Bowel Management. [s. 76. (7) 6.]

The severity of the issue was determined as a level 2 as there was a potential for actual harm to residents in the home. The scope of the issue was a level 2, a pattern. The home had a level 4 history as they had a previous Compliance Order issued on report #2017_551526_0007 on May 11, 2017. (508)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 13, 2019

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Ordre(s) de l'inspecteur

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Roseanne Western

Service Area Office /
Bureau régional de services : Hamilton Service Area Office