Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Oct 2, 2020	2020_704682_0010	008647-20, 012983-20, 015667-20, 016586-20, 016594-20	Critical Incident System

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

AILEEN GRABA (682), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): September 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 2020.

This inspection was completed concurrently with Complaint inspection 2020_704682_0009.

The following Critical Incident inspections were completed during this inspection:
008647-20 related to lifts and transfers
012983-20 related to prevention of abuse and neglect
015667-20 related to prevention of abuse and neglect
016586-20 related to prevention of abuse and neglect
016594-20 related to prevention of abuse and neglect

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), maintenance staff, restorative aide and residents.

During the course of this inspection, the inspector(s) observed the provision of the care and reviewed clinical health records, investigation notes, staffing schedules, program evaluations, meeting minutes, policy and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that a resident was protected from physical abuse.

Ontario Regulation 79/10 (O.Reg. 79/10), s. 2 (1) defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Investigative notes indicated that a resident injured another resident. Progress notes identified that the registered nurse assessed the resident's injury. The resident's care plan indicated that they had a history of responsive behaviour and interventions in place to manage the behaviours. The RN was informed of the details of the incident by the injured resident. A RPN confirmed that the resident had exhibited responsive behaviours in the past and interventions were in place. Staff did not implement interventions and placed resident's at risk for harm/injury.

Sources: The LTCH's investigative notes, resident care plan, progress notes, RN and RPN interview. [s. 19. (1)]

2. The licensee has failed to ensure that a resident was protected from physical abuse.

The home's investigation and progress notes indicated that a resident had an altercation with another resident that resulted in an injury. The review of the resident's care plan indicated that they had a history of responsive behaviours. Several interventions were in place. A RPN was interviewed and confirmed information as documented in the home's investigation record and the residents' health records.

Sources: The LTCH's investigative notes, resident care plan, residents and progress notes, RPN interview. [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 ensure that all residents are protected from abuse by anyone, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed ensure that staff members used equipment, devices, and positioning aids in accordance with manufacturers' instructions.

Investigative notes indicated staff were providing care for a resident and used an assistive device. When doing so, the resident sustained an injury. The resident required medical attention. The manufacturer's instructions had information for staff on the use of the assistive device. The Director of Care (DOC) confirmed in an interview that this information was part of the training in the home.

Sources: The LTCH's investigative notes, Manufacturer's Instructions, resident progress notes, DOC interview. [s. 23.]

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 staff use all equipment, devices, and positioning aids in the home in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

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 a resident demonstrating responsive behaviours, actions were taken to respond to the needs of the resident, including, reassessments and interventions and that the resident's responses to interventions were documented.

Investigative notes indicated that a resident injured another resident. The resident's care plan indicated that they had a history of responsive behaviours with interventions. The DOC was interviewed and said that an intervention for the resident's responsive behaviours was not effective. Without reassessing and documenting the resident's responses to the intervention, the resident was at ongoing risk for responsive behaviours.

Sources: The LTCH's investigative notes, resident's care plan, progress notes and DOC interview. [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 each resident demonstrating responsive behaviours, 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the person who had reasonable grounds to suspect that when improper care of resident resulted in harm, the information was immediately reported upon which it was based to the Director.

A resident was injured when staff were providing care. The following day, registered staff reported the incident to the Ministry of Long Term Care (MLTC) when they were notified as the registered staff at the time of the incident did not report immediately.

Sources: The LTCH's investigative notes, including the RN #106 statement and RN #106 interview. [s. 24. (1)]

2. The licensee failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Progress notes indicated that staff were aware a resident was upset. The RN interviewed the resident who reported they were upset with staff that provided care. Critical Incident System (CIS) report indicated the DOC reported the incident.The RN was interviewed and they confirmed that they did not immediately report the incident to the Director.

Sources: RN interview, CIS report, resident progress notes. [s. 24. (1)]

Issued on this 8th day of October, 2020

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

Original report signed by the inspector.