Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 2, 2016	2016_391603_0017	010238-15, 024811-15, 031587-15, 005055-16, 006552-16, 007127-16, 007283-16, 012081-16, 012087-16, 013285-16, 019485-16, 020527-16, 021489-16	Critical Incident System

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 TIMMINS
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

SYLVIE LAVICTOIRE (603), JESSICA WASYLENKI-RYAN (639), SYLVIE BYRNES (627)

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): July 25-28, 2016.

The following logs were completed during the inspection: four logs related to falls; three logs related to responsive behaviours; four logs related to allegations of abuse of a resident; one log related to personal care; and one log related to mismanagement of medications.

A Complaint Inspection #2016_391603_0016 and a Follow Up Inspection #2016_391603_0018 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, programs, and staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),Housekeeping Staff, Behavioral Support Ontario (BSO) staff, Office Manager, Residents, and Family Members.

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

During the course of this inspection, Non-Compliances were issued.
- **3 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Inspector #639 reviewed two Critical Incident Reports (CIs) submitted to the Director. Both CIs related to resident #007 falling, which caused injuries where the resident was taken to the hospital and resulted in significant change in the resident's health status.

Inspector #639 reviewed resident #007's care plan which indicated that staff were to apply a certain device to resident #007 during the morning care and remove the device with the evening care.

On a certain date, Inspector #639 interviewed resident #007 who indicated that they were not wearing the device.

Inspector #639 interviewed RPN #109 who explained that the device was to be applied to resident #007 every morning and removed at night.

Inspector #639 also interviewed PSW #113 who explained that resident #007 was to have the device applied every morning as part of their falls prevention interventions. PSW #113 confirmed that the device had not been applied on the morning that resident #007 was interviewed by the Inspector. [s. 6. (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 ensuring that the plan of care for resident #007 is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident had occurred, immediately report the suspicion and the information upon which it was based to the Director.

Inspector #627 reviewed a Critical Incident report (CI) submitted to the Director, alleging staff to resident abuse and neglect. According to the CI, resident #004's family member found a PSW to be rough when they transferred resident #004. The CI also indicated that staff took over one hour to answer a call bell on a certain evening.

Inspector #627 reviewed resident #004's progress notes which indicated that these two incidents occurred on a certain date, and were reported to the Director, two days later.

Inspector #627 reviewed the home's policy titled "Zero Tolerance of Resident Abuse and Neglect Program" #RC-02-01-01, last revised April 2016. The policy identified the following:

Under reporting:
"Any employee or person who becomes aware of an alleged, suspected, or witnessed resident incident of abuse or neglect will report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

Note: In Ontario, in addition to the above, anyone who suspects or witnesses abuse, incompetent care or treatment of a resident..., and/or neglect that causes or may cause harm to a resident is required to contact the Ministry of Health and Long Term Care (Director) through the Action Line".

During an interview with Inspector #627, RN #105 confirmed that they should have called the Action Line. RN #105 stated that at the time they had not called the Action Line as they had not recognized that this was abuse or neglect.

During an interview with the Inspector #627, the DOC stated that they had reported the incident to the Director when they became aware of it (two days after the incident). The DOC confirmed that the Action Line should have been called when the incident occurred, and this was not done.

2. Inspector #627 reviewed a CI submitted to the Director. The CI alleged staff to resident verbal/emotional abuse. According to the CI, resident #017 reported to their family member that four days earlier, PSW #119 was rude to them.

Inspector #627 reviewed the home's investigation notes which indicated that the resident's family member sent an email, with their concerns regarding alleged staff to resident abuse to the DOC, on a certain date. The home started their investigation three days after receiving the email and the alleged incident was not reported to the Director until four days after receiving the email.

During an interview with Inspector #627, the DOC confirmed that the alleged staff to resident verbal/emotional abuse should have been reported to the Director on the date when they became aware of it, and this was not done. [s. 24. (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 ensuring that the person who has reasonable grounds to suspect that abuse of a resident has occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff received the required training annually for behaviour management.

Inspector #627 reviewed a CI submitted to the Director, regarding a certain responsive behaviour displayed by resident #008.

Inspector # 627 reviewed resident #008's health care record which indicated that they had a history of a certain responsive behaviour prior to admission. A review of the progress notes in regards to this incident indicated that resident #008 had been displaying a certain responsive behaviour at the start of an evening shift. The resident continued to display the certain responsive behaviour, and assistance was required to manage the certain responsive behaviours of the resident.

During an interview with Inspector #627, RN #112 and PSW #111indicated that they did not receive much training in responsive behaviours.

The Inspector reviewed the 2015 training records for the courses titled "Memory Care (Part 1) - Cause and Effect", which referred to caring for persons with dementia and "Memory Care (Part 2)- Caring Approaches", which referred to caring for residents with responsive behaviours. The training records revealed that 78 of 148, or 53 per cent of staff members (RNs, RPNs, and PSWs) did not complete the "Memory Care (Part 1) Cause and Effect" and 82 of 148 or 55 per cent of the staff members (RNs, RPNs, and PSWs) did not complete the "Memory Care (Part 2)-Caring Approaches".

Inspector #627 interviewed the DOC who confirmed that not all staff had completed the required annual training. [s. 221. (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 ensuring that all direct care staff receive the required annual training for behaviour management, to be implemented voluntarily.

Issued on this 3rd day of November, 2016

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

Original report signed by the inspector.