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 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
Nov 26, 2018	2018_621547_0027	010455-18, 011241-18, 020894-18	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 West End Villa
2179 Elmira Drive OTTAWA ON K2C 3S1

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

LISA KLUKE (547)

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): August 9,10,13, 14, 15, 2018

The following complaint inspections were conducted concurrently during this inspection:

Log #010455-18 regarding concerns related to transfers and positioning of a resident, plan of care and reporting of incident issues,
Logs #011241-18 and #020894-18 regarding concerns related to responses for applicants Long-Term Care applications for admission to the home.

During the course of the inspection, the inspector(s) spoke with residents, resident families, Health Care Aides (HCA), Registered Practical Nurses (RPN), Registered Nurses (RN), Clinical Care Coordinators, an Office Manager, Unit Clerks, the Maintenance Manager, the Director of Care and the Administrator. The inspector also spoke to a Manager of Patient Services with the South East Local Health Integrated Network and a Care Coordinator at the Champlain Local Health Integrated Network.

In addition, the inspector reviewed resident health care records and internal investigation documents, employee schedules and work assignments relevant to this inspection. The inspector observed the delivery of resident care and services and staff to resident as well as resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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.

On a specified date, the Director of the Ministry of Health and Long-Term Care received a complaint regarding concerns related to an incident involving resident #001 during a mechanical lift transfer that was not reported as required. The complainant indicated the resident's Substitute Decision Maker (SDM) was not informed about the resident's injury and no assessments were made for the resident's pain to specified limbs. The complainant identified information regarding this incident was provided by the resident and the resident's SDM.

Inspector #547 observed resident #001's health care records that indicated the resident required total assistance of mechanical lift with two staff members by utilizing a specified sling.

PSW #100 indicated to inspector #547 that the resident previously resided on another floor and used a specified lift and since PSW #100 was not a regular staff member on the resident's unit the evening of the incident, assumed the resident had the same transfer needs. PSW #100 indicated not having read the resident's plan of care prior to providing care to the resident that evening, whereby resident #001 had a weak spell during the transfer that required PSW #104's assistance to physically assist the resident into bed.

The Director of Care indicated to inspector #547 that PSW #100 and PSW #104 did not transfer the resident to bed with the appropriate mechanical lift transfer equipment that caused the resident to slip into PSW #104's arms that caused a strain to the resident's limb.

As such, resident #001 was not transferred to bed on a specified date by PSW #100 and #104, as specified in the resident's plan of care using a mechanical lift with a specified sling.(Log #010455-18) [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 to ensure that care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 has failed to ensure that PSW staff use safe transferring and positioning devices or techniques when assisting the resident.

On a specified date, resident #001 was transferred to bed using a specific type of lift and sling by PSW #100 and #104. Resident #001's plan of care identified the resident required total assistance of two staff members, for transfer by use of another type of lift and sling.

Resident #001 indicated to inspector #547 having told PSW #100 that the resident needed another type of lift, however PSW #100 would not listen to the resident and indicated the resident could try. Resident #001 indicated feeling weak as soon as in a standing position, when PSW #104 scooped the resident up before falling to the floor and placed the resident in bed. Resident #001 indicated to inspector #547 not recalling if the resident actually hit the floor or not, but that the resident was scared and sore, as the resident tried to stand up and caused specified muscle strain. Resident #001 indicated one of the specified limbs continues to be swollen and sore, almost three months after the incident occurred.

PSW #100 indicated to inspector #547 to have worked with resident #001 on another unit before, when the resident required a specified lift and thought the resident could do this again on the date of the incident. PSW #100 indicated that PSW #104 also informed PSW #100 that this was the wrong lift to use for resident #001 when that PSW arrived for the two person assistance, however both PSW's proceeded to transfer the resident using the specified lift.

The Director of Care indicated that PSW #100 and #104 should have used the specified lift as identified in the resident's plan of care and PSW #104 should have assisted resident #001 gently to the floor instead of lifting the resident into bed, that may have contributed to the resident's specified muscle strain from this incident.

As such, PSW #100 and #104 used an unsafe transferring and positioning device and technique when assisting resident #001 to bed on a specified date that caused injury and pain to the resident. (Log# 010455-18) [s. 36.]

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 safe transferring and positioning devices and techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 has failed to ensure that when withholding approval for admission, the licensee shall give the persons described in subsection (10) a written notice setting out, a) the ground or grounds on which the Licensee is withholding approval; 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; c) an explanation of how the supporting facts justify the decision to withhold approval; and d) contact information for the Director.

The written notice provided by the Licensee for resident #003 was in a format of a letter on a specified date. In this letter, the Licensee did not set out the contact information for the Director as required by this section. (Log #020894-18). [s. 44. (9) (d)]

2. The written notice provided by the Licensee for resident #002 was in a format of a letter on a specified date. In this letter, the Licensee did not set out the contact information for the Director as required by this section. (Log #011241-18). [s. 44. (9) (d)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to inform the Director no later than one business day after the occurrence of an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital.

On a specified date, resident #001 was transferred by PSW #100 and #104 to bed using a specified type of lift instead of another type of lift as specified in the resident's plan of care, whereby resident #001 sustained specified injuries. Resident #001 was sent to hospital three days later for further evaluation to these injuries and pain.

RPN #101 indicated to inspector #547 that since the resident did not fall to the floor or have any visible injury, thought that the resident must have been confused and did not report any incident.

Inspector #547 reviewed the resident's health care records that indicated resident #001 reported to the RPN and Charge RN on a specified date, two days after the incident occurred about the inappropriate transfer incident, that caused specified injuries to the resident with a severe amount of pain. The resident refused to go to hospital for further assessment that afternoon but accepted pain medication. This incident was then reported to the charge RN and the resident was sent to hospital the next day and informed the resident's SDM. Resident #001 returned to the home on the same day with recommendations for increased pain medication related to left sided injuries.

The DOC indicated no critical incident report was submitted to the Director to date for this incident that caused specified injuries to the resident that resulted with significant increased amount of pain. The home's Nurse Practitioner indicated upon assessment of the resident post incident on a specified date to have decreased range of motion and strength and noticeably edema to a specified limb. The Nurse Practitioner further indicated the resident's limb required specified interventions and specified tests to rule out further complications. (Log #010455-18) [s. 107. (3) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 162. Approval by licensee

Specifically failed to comply with the following:

s. 162. (3) Subject to subsections (4) and (5), the licensee shall, within five business days after receiving the request mentioned in clause (1) (b), do one of the following:
1. Give the appropriate placement co-ordinator the written notice required under subsection 44 (8) of the Act. O. Reg. 79/10, s. 162 (3).
2. If the licensee is withholding approval for the applicant's admission, give the written notice required under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act. O. Reg. 79/10, s. 162 (3).

Findings/Faits saillants :

1. The Licensee has failed to respond within five business days after receiving applicant #003's request for authorization for admission to the Long-Term Care home. The Licensee is required to determine whether to give or withhold approval for the applicant's admission to the home. The Licensee is then required to provide a written notice of their decision under subsection 44 (9) of the Act to the persons mentioned in subsection 44 (10) of the Act, being the applicant, the Director and the appropriate placement coordinator.

Applicant #003 had a long-term care application completed and forwarded to the Long-Term care home (LTCH) for request for authorization of admission. This application was prepared and sent by the South East Local Health Integrated Network (SE-LHIN) care coordinator on a specified date.

The Licensee failed to respond within five business days with the written notice letter to applicant #003's request for authorization for admission. On a specified date, six business days after the applicant's information and assessments were shared to the Licensee, the written notice letter was written to the applicant that indicated the Licensee was withholding approval for applicant #003's admission. The SE-LHIN identified that the written notice letter was received on a specified date, nine business days after the applicant's information and assessments were shared to the Licensee.

As such, the Licensee failed to inform the applicant, the Director and the appropriate placement coordinator as required in subsection 44(10) of the Act, when the decision to withhold the applicant from admission as required by a specified date, five business days after the applicants request was received by the Licensee.(Log #020894-18) [s. 162. (3)

2.]

2. Applicant #002 had a long-term care application completed and forwarded to the Long-Term care home (LTCH) for request for authorization of admission. This application was prepared and sent by the Champlain Local Health Integrated Network (LHIN) care coordinator on a specified date.

The Licensee failed to respond within five business days with the written notice letter to applicant #002's request for authorization for admission. On a specified date, 39 business days after the applicant's information and assessments were shared to the Licensee, the written notice letter was written to the applicant that indicated the Licensee was withholding approval for applicant #002's admission. The Champlain LHIN identified that the written notice letter was received on a specified date, 40 business days after the applicant's information and assessments were shared to the Licensee.

As such, the Licensee failed to inform the applicant, the Director and the appropriate placement coordinator as required in subsection 44(10) of the Act, when the decision to withhold the applicant from admission as required by a specified date, five business days after the applicants request was received by the Licensee.(Log #011241-18) [s. 162. (3) 2.]

Issued on this 27th day of November, 2018

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

Original report signed by the inspector.