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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2017	2017_561583_0021	025217-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BRAMPTON
7891 Mclaughlin Road BRAMPTON ON L6Y 5H8

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

KELLY HAYES (583), DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): Novemember 6, 7, 8, 9 and 10, 2017.

During the course of this inspection, the following additional inspections were conducted:

Critical Incident System (CIS) Inspection: Log #007650-17, related to abuse.

Complaint Inspections: Log 007779-17, related to abuse and personal support services and log #009367-17, related to personal support services.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Office Manager, Program Manager, Clinical Practice Leader, Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, Maintenance Supervisor, Food Service Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and Residents and Residents` Family Members.

During the course of the inspection, the inspector(s) observed the provision of care and services, toured the home, and reviewed relevant documents including but not limited to meeting minutes, policy and procedures, menus and clinical health records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

8 WN(s)
5 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

s. 6. (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).

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 there was a written plan of care for each resident that set out the planned care for the resident, the goals the care was intended to achieve and clear directions to staff and others who provided direct care to the resident.

A) The clinical record review for resident #009 revealed that the resident was on scheduled dose of medication once daily for their medical condition. Resident #009 also had an order for two additional medications that were to be given as needed (PRN) depending on their condition. Progress notes indicated that resident demonstrated this

condition where the medication was required. Resident #009 also had three incidents in 2017 where this condition was more heightened as a result of the incidents when the medication was required.

The RPN #117 confirmed resident #009 complained of the condition and was on scheduled and as needed (PRN) medications. The written plan of care was reviewed for resident #009 and did not set out the planned care for the resident in relation to this condition and did not set goals to be achieved and did not set out clear direction to staff and others who provided direct care to the resident related to the condition.

The DOC was interviewed and confirmed that resident #009 complained of the condition and was seen by the home's Nurse Practice Leader. The DOC confirmed that the written plan of care should have included a focus related to this condition for this resident. The home failed to ensure that the written plan of care set out the planned care for the resident with clear direction for staff and goals to be achieved related to the condition.

B) Resident #008 had a plan of care indicating that they were at high risk for falls and had interventions in place to prevent falls.

An interview was completed with PSW #102, who provided direct care to the resident. It was identified that resident #008 had a variety of interventions in place to reduce their risk of falls. In an interview with RPN #101 they indicated that resident #008 needed some of the interventions at night and some during the day.

The written plan of care was reviewed and did not provide clear direction to staff related to when to use some of the interventions that needed to be specified. The kardex (a document that PSWs use to guide care for residents and was an extension of the written plan of care) was reviewed and a number of the falls interventions that were in the care plan were not listed. The interview with the PSW #102 confirmed that they used kardex and that these interventions were not included.

The home failed to ensure that the written plan of care provided clear direction to staff related to falls interventions and that the kardex set put the planned care for the resident.

2. The licensee failed to ensure that the care set out in the plan of care was based on the resident's preferences.

A review of resident #005's sleep and rest pattern plan of care identified that they preferred to get up in the morning early between specified hours. During an observation in November 2017, resident #005 was noted to be in bed past the time their plan specified they preferred to get up. In an interview with the resident they confirmed it was their preference to stay in bed, and that staff were accommodating this. They shared their preference was to receive help with getting up later than it was specified in their plan.

In an interview with registered staff #106, in November 2017, it was confirmed that resident #005's sleep and rest pattern plan of care was not based on their preference. [s. 6. (2)]

3. The licensee failed to ensure that the resident's substitute decision-maker was given an opportunity for participate fully in the development and implementation of the resident's plan of care.

The plan of care for resident #009 indicated that the resident had a fall in 2017 and sustained an injury. Resident #009 was not sent to the hospital for an assessment. The progress notes were reviewed and indicated that a note was left in physician's book about resident's fall.

The resident's Substitute Decision Maker (SDM) was interviewed and indicated that they were upset that resident #009 was not sent to the hospital and based on the injuries they sustained, they felt resident should have been.

Clinical record review revealed that when resident fell a progress note was made requesting that the family be notified. Approximately five hours later the SDM was notified. A progress note, revealed that the SDM reported to the home after visiting the resident that they felt the resident should have been sent to the hospital for further assessment.

In an interview with the RPN #117 it was revealed that when a resident sustains the type of injury resident #009 had, the physician should be called. If injury is not significant the staff monitor the resident and add the note in physician's book for the physician to assess the resident on the next visit. The RPN checked the physician book and it was confirmed a note was not entered to notify the physician of this resident's fall.

The resident's SDM was not provided an opportunity to fully participate in development

and implementation of the plan of care concerning resident #009's transfer to the hospital after they sustained injuries from the fall.

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection. [s. 6. (5)]

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

A) Resident #003 was observed in November 2017, during the evening shift while they were in bed and interventions related to bed safety and falls prevention were observed to be in place.

The current written plan of care was reviewed and indicated that the resident required a specified intervention while in bed. RPN #115 checked the care plan and confirmed that the specified intervention was to be applied and that it was only in place on one side of the bed at the time of the intervention. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. (561)

B) During an observation completed by LTCH Inspector #561 in November 2017, in the evening, resident #012 was observed lying in bed watching television and their call bell was not in reach. It was found on the floor behind the resident's bed. Registered staff #111 was present and confirmed it should have been in place.

During a second observation completed by LTCH Inspector #583 in November 2017, in the afternoon, resident #012 was observed sitting in their room in their wheel chair with foot pedals in place. Their call bell was not in reach and the breaks were not applied on the wheel chair. The call bell was found sitting on another chair in the resident's room. PSW's #121 and #122 were present and confirmed the call bell should have been in place and that the breaks should have been applied to the resident's wheel chair. They shared the resident #012 was able to use their call bell to call for assistance and both interventions were required as fall prevention strategies.

In an interview with registered staff #106 it was confirmed that resident #012's call bell was not in place as required as part of the resident's plan of care.

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection. (583) [s. 6. (7)]

5. 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.

A) Resident #003 had a plan of care indicating that they were at high risk for falls and the current written plan of care indicated that one of the interventions in place was a night light to enhance vision and prevent falls at night.

Resident #003 was observed in November 2017, during the evening shift. The resident was in bed, however the night light was not on. RPN #115 indicated that the resident did not like the night light on and it was removed some time ago. It was confirmed that the falls care plan was not revised when the care set out in the plan was no longer necessary.

B) In November 2017, an interview was completed with PSW #110 who provided direct care to resident #003. PSW #110 was also the falls lead in the home. The PSW indicated that resident #003 was a frequent faller and required frequent checks related to their medical conditions. Resident #003 was on a toileting schedule as they attempted to self-transfer which led to falls. The PSW stated that they implemented every 30 minute checks a week earlier.

The written plan of care was reviewed and did not include this intervention. The PSW confirmed that the written plan of care was not revised when this intervention was implemented. The licensee failed to ensure that the written plan of care was revised when the care needs changed for resident #003. [s. 6. (10) (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 the written plan of care sets out the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident; to ensure the resident's substitute decision-maker is given an opportunity to participate fully in the development and implementation of the resident's plan of care, to ensure care set out in the plan of care is provided to the resident as specified in the plan and to ensure the resident's plan of care is reviewed and revised when the resident's care needs change or the care set out in the plan of care is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

For the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "verbal abuse" means,
a) Any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On an identified date in 2017, the Administrator of the home heard staff yelling at a resident. PSW #123 was heard saying belittling comments to resident #011. The resident asked the staff to stop yelling at them. The Administrator then heard PSW #123 yelling and saying intimidating comments. The Administrator then intervened and removed the staff from providing care to the resident.

The home completed an investigation and identified verbal abuse had occurred and action was taken.

In an interview with the DOC on November 10, 2017, it was confirmed that resident #011 was not protected from abuse. [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 #3: 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. Where required to have, institute or otherwise put in place any policy or program the licensee failed to ensure that the policy or program was complied with.

A) In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including a falls prevention program, were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The home's policy titled "Prevention and Management Program", policy number RC-15-01-01, revised February 2017, indicated that a Clinical Monitoring Record (CMR) must be completed if resident hits their head or is suspected of hitting their head (eg., unwitnessed fall). The example of the CMR was attached in Appendix 10 of the policy.

Resident #009 had an unwitnessed fall in 2017. The health care records were reviewed (electronic and physical chart) and no CMR could be found. RPN #117 was interviewed and indicated that the CMR was to be initiated when there was an unwitnessed fall and was to be completed electronically in PCC. The DOC confirmed that the CMR was not completed for resident #009 as expected.

The licensee failed to ensure that the home's falls prevention and Management Program was followed.

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection.

B) In accordance with Ontario Regulation 79/10, s.48, required the licensee to ensure that the interdisciplinary programs including a pain management program, were developed and implemented in the home and each program must, in addition to meeting the requirements set out in section 30, provide for screening protocols; and provide for assessment and reassessment instruments. O. Reg. 79/10, s.48

The policy titled "Pain Identification and Management", policy number RC-19-01-01, last updated February 2017, indicated that a registered staff were expected to assess residents for pain using the Pain Flow Note in PCC when resident states they have pain.

The clinical record for resident #009 was reviewed and indicated that resident complained of pain on three identified dates over a one month period and received as needed (PRN) medications. The clinical record review revealed that the Pain Flow Note was not completed on those days.

RPN #117 was interviewed and stated that a Pain Flow Note was to be completed when resident complains of pain and as needed medication was given as a result. The DOC confirmed that the home's policy was not complied with when staff did not complete the Pain Flow Note assessment when resident complained of pain on those days.

The licensee failed to ensure that the home's Pain Identification and Management Policy was complied with.

This area of non-compliance was identified during a complaint inspection, conducted concurrently during this inspection.

C) Ontario Regulation 79/10 section 136 (2) 2. States that any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

The home's policy titled "Management of Narcotic and Controlled Drugs", policy number RC-16-01-13, dated February 2017, indicated that the home was to maintain a separate storage area for discontinued narcotic/controlled drugs.

RPN #121 was interviewed in November 2017 and indicated that all narcotics that were to be discontinued were stored in the narcotic bin in the medication cart until a second nurse at shift change arrived, counted the medications and provided the second

signature. Then the narcotics were disposed of. The interview with the DOC revealed that they and another designated person were the only two staff that had the key to the narcotic bin. The narcotic bin was observed and was bolted to the floor and double locked in a locked room; the slot was narrow. The DOC stated that if a bigger medication such as ampules did not fit through the opening, and needed to be disposed of during the weekend, they would remain in the narcotic bin in the medication cart until the DOC was available. The DOC confirmed the other designated person did not work on weekends.

The home failed to ensure that they followed the home's policy in relation to the management of narcotics. They did not ensure that the narcotics to be destroyed were always kept separate from any controlled substances available for administration. [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 requires the licensee of a long-term care to have, institute or otherwise put in place any policy, the licensee is required to ensure the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that (a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review were implemented, (c) and a written record was kept of everything provided for in clause (a) and (b).

An interview was completed with the DOC in November 2017, to review the home's process related to medication incidents and adverse drug reactions. The DOC reported medication incidents were documented under risk management and stated that once the incident was reported to them, they were to initiate the investigation and all records were kept in the employee file. The pharmacy was notified after each incident and the outcomes of the investigations were documented under the risk management report.

The DOC confirmed that the home did not complete a review of all medication incidents and adverse drug reactions that occurred in the home in 2017. The Administrator was interviewed and indicated that the home holds Professional Advisory Committee (PAC) meetings quarterly with an interdisciplinary team including the pharmacist and they will add this to the agenda for the next quarter.

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse reactions that occurred in the home in 2017. [s. 135. (3)]

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 (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that occur in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, (c) and a written record is kept of everything provided for in clause (a) and (b)., to be implemented voluntarily.

WN #5: 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 to ensure that staff used all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The manufacturer's instructions for ArjoHuntleigh Alenti tub lift, dated September 2010, indicated that the safety belt must be used at all times.

On November 6, 2017, during the initial tour of the home, LTCH Inspector #561 found a tub lift, ArjoHuntleigh Alenti, in the spa room of a home area without a safety belt. PSW #104 was interviewed and indicated that the safety belt was kept in a cabinet and indicated that not all residents required the seat belt to be used while they were provided baths. The PSW also confirmed that there were a few residents on the home area that were ambulatory and when they were being provided a bath the safety belts were not being used. The PSW was not aware where the manufacturer's instructions were being kept. RPN #103 was interviewed and indicated that they were not aware were the manufacturer's instructions were being kept.

The DOC was interviewed on November 6, 2017 and stated that the manufacturer's instructions were kept with the Environmental Manager. On November 7, 2017, the DOC and Charge Nurse #105 provided the manufacturer's instructions for the Alenti tub lift and indicated they were kept in the cabinets of each tub room. They both confirmed that the safety belts were to be used at all times with all residents.

The licensee failed to ensure that staff used all equipment in the home in accordance with the manufacturer's instructions. [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, supplies, devices, assistive aids and positioning aids in the home in accordance with manufactures' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

During the Resident Quality Inspection, three residents triggered for falls. Those residents were inspected and during the inspection several areas of non-compliance were identified related to falls. The Falls Lead, PSW #110, was interviewed in November 2017, and indicated that each month the home held meetings to discuss residents that fell frequently and that the DOC kept documentation of those meeting minutes.

In an interview the DOC they indicated that those meetings were called 'high risk rounds' and were not specific to falls. The DOC confirmed that there were no meetings held as part of the Falls Committee since January 2017 and the falls in the home were not analyzed. The policy titled "Falls Prevention and Management Program", policy number RC-15-01-01, dated February 2017, stated that the home was to keep continuous quality improvement processes and one part of it was to review fall trends at the Falls Prevention Committee to identify opportunities for improvement.

The licensee failed to ensure that the falls prevention and management program was implemented in the home with the aim to reduce the incidents of falls. [s. 48. (1) 1.]

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

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for each resident who was incontinent that an individualized plan, as part of their plan of care, to promote and manage bladder and bowel continence was developed and implemented based on their assessment.

On an identified date in November 2017, resident #002 was observed to have a strong odor of urinary incontinence. The continence assessment, summary of continence status identified resident #002 was incontinent but had potential to be continent. Resident #002 required assistance from one staff with toileting.

The resident's continence and toileting care plan identified staff were to establish evacuation pattern using bowel and bladder tool/point of care task, and toilet according to resident's individualized schedule. The care plan did not specify any direction or interventions to staff as to what individualized schedule or plan was to be provided.

In an interview with PSWs #108 and #109 it was confirmed that the goal was to restore resident #002's level of continence. During the interview with the staff, it was confirmed that an individualized toileting plan to promote resident #002's continence had not yet been developed from the continence assessment completed over one month prior. [s. 51. (2) (b)]

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received retraining annually relating to the home's policy to promote zero tolerance of abuse and neglect of residents.

Training records were reviewed for both Extendicare employees and contracted employees in the dietary, housekeeping, laundry and maintenance departments. Records indicated that 153 out of 159 staff received the "Extendicare Resident Abuse and Neglect" training.

In an interview with the DOC Clerk on November 9, 2017, and through email correspondence with the Administrator on November 13, 2017, it was confirmed that all of the homes staff did not receive annual retraining on the home's policy to promote zero tolerance of abuse and neglect of residents. [s. 76. (4)]

Issued on this 3rd day of January, 2018

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

Original report signed by the inspector.