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
Feb 9, 2022	2022_861194_0001	015526-21, 015527-21, 015528-21, 015529-21, 015530-21, 015531-21, 015656-21, 015657-21, 016718-21	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 Haliburton
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Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CHANTAL LAFRENIERE (194), LYNDA BROWN (111)

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): January 10, 11, 12, 13, and 14, 2022

The inspectors inspected:
Follow up under LTCHA, 2007 s. 19(1), related to abuse
Follow up under LTCHA, 2007 s. 20(1), related to abuse policy
Follow up under O. Reg 79/10 s. 91, related to storage of hazardous materials
Follow up under O. Reg 79/10 s. 129(1), related to storage of medications
Follow up under O. Reg 79/10 s. 131(2), related to medication administration
Follow up under O. Reg 79/10 s. 229(4), related to infection control
Follow up under O. Reg 79/10 s. 73(1), related to proper positioning of residents
Follow up under O. Reg 79/10 s. 52(2), related pain assessments
An incident related to resident fall.

During the course of the inspection, the inspector(s) spoke with Residents, Administrator/Director of Care, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Housekeeping and Essential Care Giver (ECG).

During the course of the inspection, the inspectors reviewed clinical health records of identified residents, COVID-19 screening and testing logs, reviewed hazardous material , oxygen, medication, hand hygiene and PPE's audits and staff educational records, applicable policies and programs related to abuse, pain and falls. The inspectors observed staff to resident provision of care, COVID-19 screening, meal service, medication administration and infection control practices.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 129. (1)	CO #004	2021_673672_0030	194
O.Reg 79/10 s. 131. (2)	CO #005	2021_673672_0030	194
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2021_673672_0030	194
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2021_673672_0030	194
O.Reg 79/10 s. 229. (4)	CO #006	2021_673672_0030	111
O.Reg 79/10 s. 52. (2)	CO #002	2021_673672_0031	111
O.Reg 79/10 s. 73. (1)	CO #001	2021_673672_0031	111
O.Reg 79/10 s. 91.	CO #003	2021_673672_0030	111

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. (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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee shall ensure that there is a written plan of care for each resident that sets out planned care for the resident.

A resident verbalized pain, was receiving assessment and interventions for pain management. The written plan of care for the resident did not set out planned care for pain. Failing to set out planned care for the resident increases the risk of the care issue not being assessed in the future. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the written plan of care sets out clear direction to staff and others who provide direct care to the resident.

A resident was provided interventions for responsive behaviours and falls. Review of the

plan of care indicated the interventions were still active after being discontinued The ADOC confirmed that the interventions had been discontinued and should have been removed from the plan of care. Failing to ensure that the written plan of care set out clear direction, increases the risk of injury to the resident and confusion to staff assisting the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that the assessments are consistent and complement each other.

A resident had a number of falls during a reviewed period. The plan of care indicated that the resident was at high risk for falls and interventions have been implemented. On an identified date the resident had a fall. One of the fall interventions were determined to be the cause of fall and was discontinued. Later the same day the resident had a subsequent fall, as the intervention had not been removed. The ADOC confirmed that the fall intervention, not being discontinued resulted in the residents second fall.The nursing staff failing to collaborate with each other in the assessment of the resident resulted in an additional fall for the resident. [s. 6. (4) (a)]

4. The licensee failed to ensure when the plan of care was revised because the care set out in the plan had not been effective, different approaches been considered in the revision of the plan of care for two residents.

One resident was at risk for falls related to several factors. Staff were to observe and ensure that the residents falls interventions were in place. The resident was observed to be primarily in bed, was noted with an unsteady gait at times, with falls interventions in place. During a specific period, the resident was noted to have frequent falls resulting in injuries. An RN indicated the resident sustained multiple falls related to high risk factors and behaviours. The RN indicated that pharmaceutical interventions were initiated for the resident’s responsive behaviours. When the resident continued to have repeated falls, there were no other interventions considered. Pharmaceutical interventions increased the resident’s risk for falls. Several falls interventions were initiated after the resident had a significant injury. Failing to revise the care set out in the plan when it has not been effective and considering different approaches in the revision of the plan of care, led to the resident sustaining a serious and potential for further injuries.

Sources: CI, observations of a resident, progress notes, pain assessments, care plan, Head Injury Routines, electronic medication administration records (eMAR), post fall

assessments for the resident, pain identification and management policy and interview of staff (RN and DOC).

Another resident was identified as a high risk for falls, with interventions. The clinical health records for the resident indicated that the resident had several falls in the reviewed period. The PT indicated that the plan of care had been reviewed but no changes had been implemented. Interview with PSW and ADOC verified that the resident did not have specific falls interventions in place. The plan of care related to falls, for the resident was not effective as the resident continued to fall. Failing to revise the care set out in the plan when it has not been effective and considering different approaches in the revision of the plan of care, increased the resident's risk of falls.

Sources: Resident clinical health records, interview with staff (PSW and ADOC) [s. 6. (11) (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 by ensuring that there is a written plan of care for each resident that sets out planned care, clear direction to staff and others who provide direct care, that staff collaborate with each other in the assessment of the resident so that their assessments are consistent and compliment each other, that the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

WN #2: 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 the pain management program was implemented in the home to identify and manage pain for a resident.

Registered staff were to complete a comprehensive pain assessment for residents upon readmission from hospital, with any new pain or new diagnosis of a painful disease and for behaviours, when pain was suspected. The PAINAD was also to be used to assess cognitively impaired residents or residents unable to verbally express their pain. The pain assessment was also to be used to develop the plan of care and to make referrals to other health professionals.

The DOC indicated the Registered staff use the Head Injury Routine (HIR) for monitoring pain, which included the PAINAD and staff were expected to follow the pain policy for completing pain assessments. An RN confirmed they completed an electronic pain assessment tool, progress notes and documented on the electronic Medication Administration Record (eMAR) when giving pain medications and the HIR only included the pain level. The RN indicated that a resident had intermittent pain, was not always able to verbalize their pain and staff needed to also assess their pain based on their increased responsive behaviours. The RN indicated they suspected the resident had unmanaged pain due to ongoing responsive behaviours.

The resident who frequently had vague complaints of pain was prescribed routine analgesic, demonstrated ongoing responsive behaviours and had frequent falls. PSWs were to report pain to the Registered staff and offer the resident therapeutic intervention. During a reviewed period there were frequent incidents of reported pain, painful incidents and a return from hospital, involving the resident, where no pain assessments and/or interventions were completed.

Failing to ensure staff implement the pain management program, by completing a comprehensive pain assessments, redeveloping the plan of care, referring to other health professionals, led to the resident having unmanaged pain and/or ongoing responsive behaviours.

Sources: Critical Incident, observations of the resident, progress notes, pain assessments, care plan, Head Injury Routines, electronic medication administration records (eMAR), post fall assessments, pain identification and management policy and interview of staff (RN and DOC). [s. 48. (1) 4.]

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 by ensuring that a pain management program is developed and implemented in the home to identify pain in resident and manage pain, to be implemented voluntarily.

WN #3: 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 has failed to ensure that two residents who had a falls, had a post fall assessment conducted using a clinical instrument that is specifically designed for falls.

A resident, who was at risk for falls, had a number of falls during the reviewed period. No post fall assessment were completed for two of the falls. The ADOC confirmed that the post fall assessments should have been completed.

Another resident, who was at risk for falls, had a number of falls resulting in injury. There were no post fall assessments completed for several of the falls. Failing to complete post fall assessments can lead to interventions not being developed to reduce falls or mitigate the risk for injuries.

Sources: Critical Incident, observations of resident , progress notes, Head Injury Routines and post fall assessments, Clinical health records, and interview of staff (DOC, ADOC). [s. 49. (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 by ensuring 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, to be implemented voluntarily.

Issued on this 11th day of February, 2022

[redacted]

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

Original report signed by the inspector.