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 7, 2020	2020_826606_0001	022864-19, 023879-19	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 Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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

JANET GROUX (606)

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): January 6-10, 13, and 14, 2020.

The following complaint intakes were inspected:
Log #022864-19 regarding concerns about a resident's fall management and Log #023879-19 regarding allegations of neglect/improper care related to lack of nutrition/hydration.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(7) was identified in this inspection and has been issued in the Critical Incident System (CIS) Inspection Report #2020_826606_0002 (log #022229-19) which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Physiotherapist (PT), Behavioural Support of Ontario (BSO) Lead, Falls Program Lead, Registered Dietician (RD), Food Service Supervisor (FSS), Dietary Aide (DA), Maintenance Department, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Home Medical Equipment Service Provider, Substitute Decision Makers (SDM) and residents.

The inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plans of care, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
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	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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided care to the resident.

A complaint submitted to the Ministry of Long Term Care (MLTC) reported concerns with resident #001's care.

Resident #001's Substitute Decision Maker (SDM) alleged staff refused to provide care to resident #001 because of the resident's responsive behaviours.

Resident #001 was identified with responsive behaviours during an identified activities of daily living (ADL). The resident's plan of care directed the staff to provide resident #001 with an identified type of transfer assistance as recommended by the physiotherapist (PT). The plan of care also directed staff to use an identified type of transfer assistance and stated that this was requested by the resident's SDM.

Personal Support Worker (PSW) #103 stated resident #001's plan of care directed staff to use an identified type of transfer assistance for the resident when they provided the resident an identified ADL as recommended by the PT. The PSW said that because of the resident's responsive behaviours during an identified ADL, the staff also used an identified type of transfer assistance as directed by the resident #001's SDM.

The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided care to resident #001 in relations to transfers. [s. 6. (1) (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 the plan of care set out clear directions to staff and others who provide care to the resident; and to ensure that the care set out in the plan of care is 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. 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. The licensee failed to ensure that any policy put in place was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 1 and in reference to O. Reg. 79/10, s. 49 (1) the licensee was required to ensure the falls prevention management program must, at a minimum provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipments, supplies, devices and assistive aids.

A. The home's falls policy directed the interdisciplinary team to determine which residents to flag for additional monitoring, create an individualized plan addressing identified fall causes and risk factors including behavioural and environmental hazards in the prevention of falls and injury.

A complaint submitted to the MLTC reported concerns regarding resident #001's fall.

Resident #001's progress notes stated that the resident fell and sustained an injury. Review of the progress notes stated that resident #001 was observed the previous shift to be sitting unsafely in an identified chair.

PSWs #103, #106, Registered Nurses (RN) #102 and #105 stated their concerns about resident #001's identified chair being unsafe had been reported to the home but there had been no follow up to manage the issue. Resident #001's progress notes were reviewed and showed documentation on identified dates where staff reported concerns that resident #001's chair was unsafe for the resident to use.

Registered Practical Nurse (RPN) #116, the fall's lead for the Home and the Director of Care (DOC) acknowledged that when any chair or any furniture that a resident used was observed to be unsafe, the chair would be be removed from the resident's use. The maintenance department would be notified to see if it could be fixed and the family would be contacted for further assistance.

B. The home's falls policy stated that after a resident fell, registered staff were directed to transfer the resident off the floor. When a resident sustained an identified injury from a fall, and were on an particular medication, the physician would be called to obtain an order to send to hospital and the resident's SDM would be be notified. This was confirmed by RN #102 and RPN #105.

Resident #001's progress notes stated that the resident fell and sustained an identified injury. On assessment, RN #101 observed resident #001 displayed responsive behaviours. The resident continued to display the behaviours when they and PSW #106 attempted to transfer resident #001 off the floor a number of times without success. Resident #001 was provided care and remained on the floor until the beginning of the next shift. RN #102 re-assessed resident #001 with an injury and transferred them to the hospital.

Resident #001's falls and pain assessments and monitoring records during the shift contained incorrect information and were incomplete.

RN #101 stated that they assessed resident #001 and determined that their fall and injury was manageable and the resident did not require further interventions and actions as indicated in the policy. They decided to leave resident #001 on the floor because they

were not able to transfer the resident off the floor due to their responsive behaviours.

The DOC said that their investigation concluded that RN #101 did not provide care to resident #001 in accordance with the home's falls policy.

The licensee failed to ensure that the home's Falls Prevention and Management Program was complied with for resident #001.

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 any policy put in place is complied with, 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 has failed to ensure that for each resident demonstrating responsive behaviours, (a) the behavioural triggers for the resident were identified, where possible; and (b) strategies were developed and implemented to respond to these behaviours, where possible.

A complaint submitted to the MLTC reported concerns regarding resident #001's care.

The SDM alleged that staff refused to provide care to resident #001 because of their responsive behaviours.

The home's Responsive Behaviours policy directed staff to investigate the causes for the observed behaviour.

Resident #001's progress notes stated that the resident was in pain when care was provided using an identified transfer equipment and displayed an identified responsive behaviour. A pain assessment was completed and indicated the resident's pain scale was at an identified level. The resident was monitored for a number of days and it was concluded that the resident's pain had resolved. The progress notes stated the resident continued to display responsive behaviours when they were put on an identified transfer equipment on identified dates after the resident pain was concluded resolved.

The resident's plan of care directed staff to put the resident on an identified transfer equipment while they performed care despite the recommendations by the PT.

PSW #103 stated that the resident displayed an identified responsive behaviours when they were placed on an identified transfer equipment and had verbalized that they were in pain. PSW #103 stated that this was reported to the registered staff but they did not see any follow up to these observations.

The Behavioural Support of Ontario (BSO) lead stated that when a resident was having a responsive behaviour, a responsive behaviour huddle was completed with the unit staff to discuss and identify the reasons behind the behaviour and put strategies in place to manage the behaviour. The BSO lead stated that they were unaware that staff were concerned that the resident's pain and the use of the identified transfer equipment were a trigger for their responsive behaviour during care.

The licensee has failed to ensure that resident #001's behavioural triggers were identified, strategies were developed and implemented to respond to these behaviours.

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, (a) the behavioural triggers for the resident is identified, where possible; and b) strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

Issued on this 21st day of February, 2020

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

Original report signed by the inspector.