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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 4, 2017	2016_327570_0026	013459-16	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 KAWARTHA LAKES
125 Colborne Street East LINDSAY ON K0L 2V0

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

SAMI JAROUR (570), DENISE BROWN (626)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 28-30, December 1 and 2, 2016.

Resident Quality Inspection (RQI) Intake #013459-16. There were three additional intakes assigned to the RQI and such were inspected concurrently with this inspection; the intakes
assigned included: # 000889-16, 012468-16 and 030548-16.
Summary of Intakes:
1) 000889-16 – Critical Incident Report, specific to alleged staff to resident alleged verbal abuse.
2) 012468-16 – Complaint, specific to alleged neglect of a resident.
3) 030548-16 – Critical Incident Report, specific to alleged neglect of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Dietary Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), RAI-MDS Coordinator, Physiotherapist (PT), Residents' Council President, Residents and Families.

Also during the course of this inspection, the inspector(s), toured the home, observed medication administration, staff to resident interactions, and resident to resident interactions, reviewed clinical health records, meeting minutes of the Resident Councils, training records specific to prevention of Abuse and Neglect, and reviewed policies specific to Weight Change Program.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

- **6 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	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. 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 any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 5 for the purpose of the definition of "neglect" in the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Log #030548-16:

Critical Incident Report (CIR) was submitted to the Director on an identified date for an allegation of staff to resident abuse/neglect. The CIR noted that the incident occurred on an identified date four days prior. The CIR indicated that PSW #120 allegedly informed resident #024, who had incontinence on two occasions earlier in the day, that the resident would not be provided with care for incontinence in the afternoon as outlined in the plan of care. Resident #024 was toileted in the afternoon. The CIR noted that the incident occurred on an identified date and was reported to the Director four days after

the date of the incident.

A review of the resident's health records indicated resident #024 had multiple diagnosis of physical limitations; the resident's plan of care directs that the resident should be toileted on a designated planned schedule and as needed.

During an interview on December 01, 2016, RN #119 indicated to the inspector that the resident reported the incident days after it had occurred but the RN could not remember the specific date. In the same interview RN #119 indicated that the incident was reported to the DOC, one day after resident #024 had informed him/her of the incident.

In an interview on December 02, 2016, resident #024 indicated to the inspector that the incident was reported to RN #119 at midnight on the day that it had occurred. In another interview, on December 02, 2016, PSW #120 indicated that as resident #024 was toileted and care provided twice that morning, the resident had agreed not to be toileted at specific time as per planned schedule. During another interview with RPN #101 on December 02, 2016, the RPN recalled on the day of incident, PSW #120 reporting that resident #024 had agreed to omit being toileted at a specific time as per planned schedule.

In an interview with the DOC on December 02, 2016 regarding the incident which was reported to the DOC by RN #119 one day prior to submitting the report to the Director; the DOC indicated that it was determined during the investigation that the resident was provided care at midday on the day of the incident. The DOC further indicated that based on the investigation the resident had made an agreement with PSW #120 to omit the being toileted at a specified time later that day.

During the same interview on December 02, 2016, the DOC indicated that RN #119 was aware of the incident but did not report it to him/her until one day before the Director was notified of the incident. Subsequently the Director was notified of the incident on an identified date approximately four days after the incident. The DOC indicated that incidents of resident abuse or neglect must be immediately reported to the DOC or to the Administrator.

The licensee failed to immediately notify the Director of the alleged staff to resident abuse/neglect. [s. 24. (1)]

2. The licensee has failed to ensure that the person who had reasonable grounds to

suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically,
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Under O. Reg. 79/10, s. 2 (1) for the purpose of the definition of "abuse" in subsection 2 (1) of the Act, "emotional abuse" means, (a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviours or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

Under O. Reg. 79/10, s. 2 (1) 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 selfworth, that is made by anyone other than a resident.

Related to Log #00889-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, on an identified date and time, specific to a witnessed incident of alleged staff to resident verbal abuse; the incident was said to have occurred on an identified date and time approximately five days prior. As per CIR, on an identified date Registered Nurse (RN) #100 and Registered Practical Nurse (RPN) #116 reported to the DOC an incident that occurred five days prior, involving verbal abuse allegation toward resident #022 by PSW #115. Resident #022 was resistant during care; the resident was reapproached twice resulting in becoming verbally abusive to staff. PSW #115 also escalated in his/her frustration culminating in calling the resident "a degrading name".

On December 02, 2016, during an interview with the DOC, it was indicated to the inspector that both RN #100 and RPN #116 did not report the witnessed incident of staff to resident verbal abuse to him/her until five days following the incident; The DOC indicated that both RN #100 and RPN #116 witnessed PSW #115 calling the resident "a degrading name" with the resident present but failed to report the abuse incident; the DOC indicated that RN #100 indicated (to the DOC) that he/she made a terrible mistake by not reporting the incident immediately to the manager on call.

An allegation of staff to resident verbal abuse was not reported to the Director until

approximately five days following the initial reported allegation of witnessed verbal abuse involving resident #022.

The DOC indicated that the action of PSW #115 was considered abusive and that the incident of abuse should have been immediately reported to the manager on call and the Director by Registered Nurse RN #100 who was in charge of the home on the day of the incident. [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 to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident has occurred or may have occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the development of nutrition care and hydration program that includes policies and procedures related to nutrition care and dietary services and hydration, in consultation with a dietitian who is a member of the staff, was implemented.

Review of clinical records for resident #001 by Inspector #570 indicated the resident was admitted to the home on an identified date with multiple diagnoses including cognitive decline and the resident was identified at high nutritional risk.

Resident # 001's weights were reviewed by Inspector #570, and the following was noted: Resident #001 had a significant weight change of 5.5 percent drop in body weight between two identified months; Also, resident #001's weight recorded on identified later date indicated a significant weight change of 9.6 percent in body weight compared to the weight recorded on the previous month.

Review of progress notes for resident #001 by Inspector #570, in relation to nutrition and hydration indicated the resident was assessed by the Registered Dietitian (RD) on an

identified date. The RD indicated in the progress note that no reweigh was noted and requested a reweigh of the resident to be completed.

Review of the licensee's policy #RESI-05-02-07 titled Weight Change Program indicated:
Page 1 of the policy, under Procedures stated that registered nursing staff:
1. Compare to previous month's weight; and any weight with a 2.5 kg difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh the resident.
3. Review weights and determine whether weight change is significant:
a) a change of 5% or more over one month.

On December 1, 2016, during an interview, PSWs #106 and #121 both indicated to the inspector that they do not have access to the previous month's weight and that a reweigh is completed for certain residents when requested by the Dietary Manager, the RD and or the charge nurse.

On December 1, 2016, during interviews, RPN #101 and RN #100 both indicated to the inspector that weights and reweighs were to be done within the first seven to ten days of the month. RPN #101 further indicated that the RD or the Dietary Manger usually determine if a reweigh was needed. RN #100 indicated that the charge nurse or the RD can order a reweigh but the current practice is to check that residents' weights were completed by the 10th of the month. RN #100 further indicated that registered nursing staff would review weights if PSW staff reported a significant drop of weight of any resident.

On December 1, 2016, during an interview, the RD indicated to the inspector that a reweigh is needed when there is 2.5 kg variance as per policy; reweigh should be done within the next bath day. The RD indicated that resident #001 should have been reweighed when the resident had a significant change in weight.

On December 2, 2016, during an interview, the DOC indicated to the inspector that when weights are done and entered in Point Click Care (PCC), the Dietary Manager was reviewing those weights and would ask for a reweigh if needed; but registered nursing staff should review resident's weights and determine if a reweigh was needed as per policy.

Therefore, a reweigh was not completed for resident #001 when the resident had a significant change in weight in two identified months. Furthermore, registered nursing

staff did not review the resident's weights to determine if a reweigh was required or not as per the licensee's policy titled weight change program. [s. 68. (2) (a)]

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 registered nursing staff review residents' weights to determine if a reweigh is required or not and a reweigh is completed as per the licensee's policy titled weight change program, to be implemented voluntarily.

WN #3: 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 resident #021's written plan of care set out the planned care for the resident in relation to the change in resident #021's transfer status and mobility.

Resident #021 was admitted to the home on an identified date with multiple diagnoses including cognitive decline. A review of resident #021's health care records indicated the resident is at high risk for falls.

On November 30, 2016, during an interview with Inspector #570, PSW #101 indicated that resident #021 required two staff assist to walk within the room and the resident was transferred using a mechanical lift for safety. PSW #110 indicated that the resident was using a wheelchair for mobility.

Review of the current plan of care for resident #021 indicated:
- the resident was independent with mobility aid for locomotion on and of the unit; requires reminders to use mobility aid.
- the resident requires extensive assistance with mobility aid for transfers to maintain independence.

On November 30, 2016, during an interview and review of the plan of care for resident #021, RPN #101 indicated to the inspector that resident #021 started to use a wheelchair due to high risk of falling related to unsteady gait and reduced mobility. RPN #101 indicated that the written plan of care was not revised and updated in relation to the resident #021's change in mobility and transfer status.

On December 02, 2016, during an interview, The Director of Care (DOC) indicated to the inspector that resident #021's written plan of care was not revised in relation to the change in transfer and mobility status. [s. 6. (1) (a)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

During the initial tour of the home on November 28, 2016, there was an enclosed court yard observed on each of the two residents home areas by Inspector #626. There were two enclosed courtyards located on the Balsam residents home area and one enclosed courtyard on the Cameron residents home area. There were no residents observed in the home's three courtyards on November 28, 29, 30 and December 01, 2016. The inspector observed that all three resident courtyard areas did not have a resident-staff communication and response system.

In an interview on November 28, 2016, PSW #102 and RPN #101 indicated to Inspector #626 that the doors to the courtyards are kept locked and accessible with a key, which registered staff have in their possession and residents are not left unattended in the courtyards. During interviews on November 30, 2016 PSWs #109, #111 and RPN #110 indicated to the inspector that the doors to the courtyards are kept locked and accessible with a key which registered staff have in their possession and residents are not left unattended in the courtyards.

During an interview on December 01, 2016, the Administrator indicated to the inspector that he/she was aware that the courtyards did not have a call bell system. The Administrator further indicated that residents are with staff or a family member when in the courtyards and are not left unattended. The Administrator also indicated that there have been conversations around having the call bell systems installed in the courtyards.

The home has failed to ensure that the three courtyards; two located on the Balsam residents home areas and another on the Cameron residents home area are equipped with a resident-staff communication and response system. [s. 17. (1) (e)]

WN #5: 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 staff use safe transferring techniques when assisting residents.

Related to Log #000889-16:

Critical Incident Report (CIR) was submitted to the Director on an identified date for staff to resident allegation of verbal abuse involving resident #022.

Inspector #570 reviewed the licensee's investigation documentation related to the alleged incident of verbal abuse. The review indicated that PSW #115 also knowingly disregarded the licensee's lift policy and performed unsafe practice when provided care for resident #022 on the date of the incident.

Review of the plan of care current at time of incident related to bathing for resident #022 indicated transfer in and out of bathtub by two staff as per policy.

On December 02, 2016, during an interview, the DOC indicated to the inspector that PSW #115 transferred resident #022 into and out of the bathtub without the assistance of a second staff; the expectation is that when the tub chair is used to transfer a resident into or out of the bathtub, it is a requirement to have two staff to assist; PSW #115 put resident #022 in the bathtub using the tub chair lift and took the resident out of bathtub by him/herself. The DOC indicated to the inspector that PSW #115 explained that at the time of the incident other staff were too busy looking after other residents.

Interview with the DOC and review of investigation notes indicated, resident #022 was transferred with the assistance of one staff to the bath tub contrary to the directions included in the resident's plan of care. [s. 36.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse.

Related to Log #00889-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date, specific to a witnessed incident of alleged staff to resident verbal abuse; the incident was said to have occurred on an identified date five days prior.

Review of clinical records for resident #022 by Inspector #570 indicated the resident's Substitute Decision Maker (SDM) was not notified of the witnessed incident of alleged staff to resident verbal abuse until five days after the incident which was witnessed by Registered Practical Nurse #116 and Registered Nurse #100.

On December 02, 2016, during an interview with the DOC, it was indicated to the inspector that the resident's SDM should have been notified of the incident on the same day when the incident occurred. The SDM was notified of the incident approximately five days following the incident. [s. 97. (1) (b)]

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.