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

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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
Jan 4, 2018	2017_687607_0021	024654-17	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 KAWARTHA LAKES
125 Colborne Street East LINDSAY ON K0L 2V0

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

JULIET MANDERSON-GRAY (607), CHANTAL LAFRENIERE (194)

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): November 30, December 1, 4, 5, and 6, 2017

The following Intake Logs were inspected concurrently with the Resident Quality Inspection:

1) Log # 019964-17, regarding a witnessed incident of resident to resident abuse.
2) Log #'s 021813-17 and 021815-17, regarding a witnessed incident of resident to resident abuse.
3) Log # 022529-17, a follow-up to a Compliance Order related to resident to resident abuse.
4) Log # 022645-17, regarding a witnessed resident to resident abuse.
5) Log # 023336-17, regarding a witnessed resident to resident abuse.
6) Log # 024173-17, regarding a witnessed resident to resident abuse.
7) Log # 024173-17, regarding a witnessed resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Food and Service Manager (FSM), Housekeeping and Maintenance Manager (ESM), Housekeeping Supervisor staff (HSK) , Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) Health Care Aides (HCA), the President of Resident Council, family and residents.

During the course of the inspection, the inspector(s) conducted a tour of resident's home areas, observed staff to resident interactions and provision of care, medication administration, reviewed relevant home records, relevant policy and procedures, and resident health records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_687607_0015	607

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door

On an identified date and time, Inspector #607 observed the sliding door in the family room on the main floor leading out to the main entrance parking lot, to have a stick along the sill. The stick could be easily removed and the door opened without difficulty. The main floor family room is a resident accessible area; resident have been seen within this area throughout the inspection.

Inspector #607 brought the concern to the Administrator at the time of the incident, who also came to the room and had difficulties locking the door. The Administrator went and got the Environmental Service Manager (ESM), who was able to lock the door by pressing a latch at the top of the sliding door.

During an interview with Administrator, she indicated that door leading to outside of the family room leads to the front parking lot and does not have a control system in place that is kept on at all times. The Administrator indicated that ESM checks the door leading from the family room to main entrance parking lot on a daily basis, but indicated that door leading to the family room is usually left open throughout the day and is locked at nights by the evening staff. During further interview, the Administrator indicated that there is currently a "kicker plate" in place that allows that door to open only four inches, but indicated that the door is not equipped with an audible door alarm that allows calls to be cancelled at the point of activation.

The licensee failed to ensure that the door leading outside of the family room to parking lot was
I. kept closed and locked,
ii. equipped with a door access control system that is kept on at all times, and
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. [s. 9. (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 ensuring that all doors leading to the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, equipped with a door access control system that is kept on at all times, and
equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and, is connected to the resident-staff communication and response system, or is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door, specifically related to the family room leading to the main parking lot, to be implemented voluntarily.

WN #2: 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. (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 has failed to ensure that when a resident is reassessed the plan of care is reviewed and revised at any other time when the resident's care needs change or the care set out in the plan is no longer necessary.

Related to Log #024173-17 involving resident #019 and #023:

A Critical Incident Report was submitted to the Director on an identified date and time, for

a witnessed incident of resident to resident abuse. The CIR indicated that a housekeeper witnessed resident #019 resident displaying an identified behaviour towards resident #023.

A review of resident #023's clinical health care records indicated the resident is cognitively impaired.

A review of resident #019's current written care plan indicated there was interventions in place related to the residents identified responsive behaviours. The specific intervention instructed staff when the intervention was to be put in place at specific times.

On an identified date and time, Inspector #607 observed resident #019 in an identified area, the identified intervention was not in place.

During an interview with Personal Support Worker (PSW) #117, by Inspector #607, indicated that the specified intervention that was in place was related to the resident's falls rather than what it had instructed staff to do.

During an interview with Registered Practical Nurse (RPN) #112, by Inspector #607, indicated that it was discussed in a meeting on an identified date, that resident #019's written care plan was to be changed to include that the specified intervention was to be in place at different specified times. The RPN further indicated the care plan was not updated to reflect this and later updated the written care plan.

During an interview with the Director of Care (DOC), she indicated that the expectation is that residents care plan are to be updated when the resident care needs change and at any other time when the care plan requires updating.

The licensee failed to ensure that when a resident was reassessed the plan of care was reviewed and revised when the resident's care needs change, specifically related to resident #019 written plan of care was not updated to include interventions related to an identified intervention be in place at all times when the resident was in an identified area. [s. 6. (10) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (3) If not everything required under subsection (1) can be provided in a report within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director. O. Reg. 79/10, s. 104 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a preliminary report is made to the Director within 10 days, a final report was made within the time specified by the Director (in 21 days unless otherwise specified by the Director)

Related to Log # 023336-17 involving resident #013 and #019:

A Critical Incident Report was submitted to the Director on an identified date and time, for a witnessed incident of resident to resident abuse. The CIR indicated that a Personal Support Worker (PSW) witnessed resident #019 displaying an identified behaviour towards resident #013.

A review of the CIR indicated it was submitted to the Director on an identified date in 2017, further review indicated that the CIR was not amended until a month later.

During an interview with the DOC, by Inspector #607, indicated that CIR was not amended to include a final report to the Director within 21 days. [s. 104. (3)]

2. The licensee has failed to ensure that when a preliminary report is made to the Director within 10 days, a final report was made within the time specified by the Director (in 21 days unless otherwise specified by the Director).

Related to Log # 024173-17 involving #013 and #023:

A Critical Incident Report was submitted to the Director on an identified date in 2017, for a witnessed incident of resident to resident abuse. The CIR indicated that a housekeeper witnessed resident #013 displaying an identified behaviours towards resident #023.

During an interview with the DOC, by Inspector #607, indicated that CIR was submitted on an identified date in 2017, and a final report was not submitted to the Director since the date of submission. [s. 104. (3)]

Issued on this 10th day of January, 2018

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

Original report signed by the inspector.