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
Oct 20, 2021	2021_861194_0011	023967-20, 005191-21, 011617-21, 013749-21	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 Kawartha Lakes
125 Colborne Street East Lindsay ON K9V 6J2

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

CHANTAL LAFRENIERE (194)

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): August 31, 2021, September 1, 8, 9, 10, 13, 14, 15, 16, 17, 2021

Inspected Log #023967-20 and Log #011617-21, related to resident falls, Log #005191-21 and Log #013749-21, related to allegations of staff to resident abuse and neglect

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Residents.

During the course of the inspection the inspector reviewed the clinical health records of identified residents, Falls Prevention and Management Program #RC-05-01-01, internal abuse investigation notes and observed staff to resident provision of care.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. (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 ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The plan of care for resident #003, indicated that the resident required a specific number of staff for total assistance during the day/evening and night staff was to provide extensive to total assistance when in bed. The resident was not to get up until a specified time, a meal tray was to be provided. The plan of care was changed to direct that staff were to assist the resident with care at a different specified time. If the resident would like to sleep in, they would be provided a meal tray in bed and would be provided care at a specified time.

The Administrator confirmed that PSW #124 had not provided specified care to resident #003 on during a specified time as they assumed the resident would ring for assistance.

PSW# 125 stated that on the identified day, resident #003 was taken to their meal and the resident did not want it, stating that they wanted to get up immediately. Resident was upset and RPN #109 directed staff to assist the resident up out of bed during the meal service. PSW explained that the resident's routine for care was that the resident would remain in bed and would be provided a meal tray, as the resident required a specific number of staff to assist with care. PSW stated that it was hard to manage the care of the resident and continue to provide care to the remainder of the residents. The plan of care had recently been changed at the resident's requests to be assisted with care at a specified time and be up for meals. On an identified date, the resident was not able to be assisted out of bed, related to staffing on the unit.

RPN #109 confirmed that the resident #003 remained in bed on an identified date, as the unit is working short staffed.

On an identified date the resident was in bed, with meal tray on side table in-front of the resident. The resident confirmed that they required assistance with care. The resident stated that a new process had been started recently where the resident was to be assisted at a specified time. Failing to ensure that the care set up in the plan of care is provided as specified in the plan related to care, increases the risk of skin breakdown, infection and diminishes the residents dignity.

Sources: Resident #003's clinical health record, internal abuse investigation and interviews. [s. 6. (7)]

2. The licensee failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.

Resident #003 confirmed that they had complained of pain after staff attempted to reposition the resident. RPN #109 confirmed that they did not assess the resident at the time of the incident. A specific number of days later the resident was not able to participate in exercises related to pain, physio was to be notified. A specific number of days later the Physician was contacted to assess the resident for complaints of pain and confirmed the resident's injury. The following day the Nurse Practitioner (NP) assessed the resident with the same outcome and ordered treatments. Failing to ensure that the resident is reassessed when the resident's care needs change, increases the risk of further injury.

Sources: Clinical health records for resident #003 and interview (resident and RPN #109). [s. 6. (10) (b)]

3. The licensee failed to ensure that the resident was reassessed, and the plan of care was reviewed and revised when the care set out in the plan was no longer effective.

The plan of care for resident #001 related to falls indicated that the resident was at medium risk for falls, with falls interventions.

Resident #001 experienced a fall resulting in injury. The resident returned to the home a specific number of days later, with a change in condition. On a specified day, the resident

was found on the floor, with no injuries. RN #111 completed the post fall assessment and recommended that the resident required 1:1 monitoring.

The following day the resident was found on the floor with no injury. RPN #107 completed the post fall assessment, describing that the fall may have been prevented by continuing to monitor the resident and possibly assign a staff to keep an eye on the resident. RPN stated that the fall intervention was active which is what alerted PSW that the resident had moved. The RPN stated that this fall intervention had been in place for months.

The following day the resident was found on the floor with no injury, no change to the plan of care was initiated.

RN #111 indicated that they had been working at the home for a specific period of time prior to resident #001's fall and stated that the resident had fall intervention in place, which was successful. RN stated that the resident was frequently falling. RN confirmed that they had completed the post fall assessment for the resident after the fall, resulting in a transfer to hospital. RN stated that the recommendation for 1:1 staffing for the resident was identified on the post fall assessment, following the fall on a specified date. RN stated that they could not implement 1:1, the management of the home would review the post fall assessments and make those decisions.

Administrator stated that they were not aware of any 1:1 staffing for the resident in the identified period. Administrator stated that management would review the risk management forms for resident falls but not the post fall assessments.

RPN 119 stated that they did not feel that 1:1 staffing had been implemented for resident #001 post fall resulting in hospital transfer. RPN stated that there was no one that would review the post fall assessments.

RPN #115 confirmed that they were on the falls team. RPN confirmed that falls interventions were attempted with the resident since admission but were not successful. The RPN stated that the interventions were not trialled again, as the resident's behaviour had not changed. The Fall's team minutes, noted that a number of days post fall, there was discussion of trialing other falls interventions for the resident. RPN stated that registered staff did not have to wait for falls team to initiate any of the falls interventions.

RPN #110 confirmed being involved in the initial and last fall for resident #001. RPN

confirmed that no changes to the plan of care had been made related to falls. Failing to reassess the resident and review and revise the plan of care when it is no longer effective related to falls, increases the risk of further falls.

Sources: Clinical health record for resident #001, post fall assessments, Interviews. [s. 6. (10) (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 by ensuring that the care set out in the plan of care is provided to the resident as specified related, that the resident is reassessed and the plan of care reviewed and revised when the care needs change or the plan is no longer effective, to be implemented voluntarily.

WN #2: 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 failed to ensure that staff used safe transferring and positioning techniques when assisting the resident.

Resident #003 and SDM confirmed that a specific number of staff members were providing care to the resident. Resident stated that PSW #123 was assisting when they yelled out and told the PSW that it was hurting them, but that the PSW continued.

RPN #109 stated during this period resident #003 was refusing to get out of bed because of their mobility aide. The resident's bed had been put against the wall and staff were to move the bed, with all care needs.

The internal investigation statements stated that PSW #121 was unable to see what took place at the time of the incident, only that the resident was yelling when PSW #123 was near them. PSW #122 confirmed that PSW #123 had placed their hands under the resident. The resident began to scream, stop, PSW #123 had not removed their hands, the resident then yelled at PSW #123 to get out of their room. PSW #123 stated that they had placed their hands under the resident but did not have time to do anything before the resident began to yell. A specific number of days later, the physician documented in the progress notes that the resident had an injury. The following day, the physician ordered further assessments. The NP documented in the progress notes that the resident had an injury and ordered treatments. Failing to ensure that staff use safe transferring and positioning techniques when assisting the resident, increases the risk of injury.

Sources: Clinical health records for resident #003, Internal abuse investigation and interviews. [s. 36.]

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 the staff use safe transferring and positioning techniques when assisting the residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director is informed no later than one business day after the occurrence of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's, health condition.

Resident experienced a fall on an identified date, resulting in hospital admission. The resident's progress notes indicated that the hospital informed the home of the resident's admission later that day. The resident returned to the home with a change in condition. The Director was informed of the resident's fall, a number of days after the incident. Administrator stated that the home was late in reporting the fall to the Director. Failing to inform the Director within the legislated time frame for an incident resulting in an injury, poses a minimal risk to residents.

Sources: CIR, clinical health record for resident #001, Interview. [s. 107. (3) 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 the Director is notified no later than one business day where an incident occurs that causes an injury to a resident for which the resident is take to a hospital and that results in a significant change in the resident's, health condition, to be implemented voluntarily.

Issued on this 22nd day of October, 2021

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

Original report signed by the inspector.