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 apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 20, 2021	2021_861194_0010	010993-21	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 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

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 31, September 1,8, 9,10,13, 14, 15, 16, 17, 2021

Inspected Log #101993-21 complaint related to care of a resident

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Environmental Services Manager (ESM), Housekeeper, Security Guard (SG), Clinical Co ordinator, Regional Director, Dietitian, Physician, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW)

During the course of the inspection, the inspector, observed resident rooms, staff to resident care, infection control practices, meal service and temperatures in the home. The inspector reviewed clinical health record of identified residents, Food and Fluid intake Policy, Odour Control Investigation Tool, appendix 1, Height and weight Monitoring policy , Complaint and Customer Service policy

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Dining Observation
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the SDM of resident #001 had been provided the opportunity to participate fully in the development and implementation of the plan of care related to a specific treatment.

Over an identified period the progress notes for resident #001 indicated a decline in the residents care requiring a treatment. SDM of resident #001 confirmed that they had not been informed of the resident's change in condition. Interviews with RPN #109 and Dietitian confirmed that they had not informed the SDM of the change in condition for the resident. Failing to provide the SDM with the opportunity to participate in the development and implementation of the plan of care could result in increased risk of further decline, related to not being aware of how to care for the resident.

Sources: Resident #001 clinical health records, TARS and interviews. [s. 6. (5)]

2. The licensee has failed to ensure that the care set out in the plan related to specified testing were provided to the resident as specified in the plan.

A physician's order was received for resident #001, to have regular testing, for a set period. Review of the clinical health recorded for the resident confirmed that the testing was not completed for the resident as ordered. Interview with RPN #115 confirmed that there were no results available for the month missed.

Sources: clinical health record and interview. [s. 6. (7)]

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 the SDM is provided the opportunity to participate fully in the development and implementation of the resident's plan of care and by ensuring that the care set out in the plan of care is provided as specified, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the housekeeping program, procedures were developed and implemented for addressing incidents of lingering offensive odor.

Inspector #194 noted an offensive odor in resident #014, #015 and #016 rooms. PSW #114 stated that they were aware of the odor. PSW #114 also stated that the home utilized Mattress protectors on the beds. ESM confirmed that the home utilized a charcoal product for odor control and Vapour Tech machines. ESM stated that they would first assess the odor to try and eliminate the source before trying the other methods. ESM stated that PSW and Housekeeping staff had not made him aware of the odors in the identified resident's rooms. CC #115 confirmed that new mattress protectors had been purchased and the routine of changing the mattress cover with linens weekly would be incorporated in the homes practice for changing bedding. Failing to develop and implement procedures to address the incidents of lingering offensive odors, reduces the quality of life for residents.

Sources: Tour of the home, interview with staff.[s. 87. (2) (d)]

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 procedures are developed and implemented to address incidents of lingering offensive odor, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #010 was dressed in their own clean clothing.

Resident #010 was observed with soiled clothing after a meal and remained this way for a number of hours. Resident #010 was assisted to the bathroom at a specified time by PSW #112 where their clothes were changed. RPN #109 confirmed that the unit was short one staff. A meal was late, beds unmade, staff running to complete care, stating it was very hectic on the unit. The RPN observed the resident with soiled clothing when repositioning the resident at a specific time and placed the resident, in front of the nursing station.

Sources: observation of resident #010 and interview. [s. 40.]

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 each resident of the home is assisted with getting dressed as required, and is dressed appropriately, in their own clean clothing, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that residents linens were changed at least once a week and more often as needed.

Residents # 014, #013 and #009's bed were inspected by Inspector #194 at a specific time and noted to have soiled fitted sheets on the bed. The next day, resident #017's, #018 and #019 beds were noted to have soiled fitted sheets on the bed. The Administrator stated that sheets are to be changed on bath days and when soiled. DOC was informed of the soiled sheets on resident #017, #018 and #019's bed and confirmed that it would be addressed. Failing to ensure that the resident's linens are changed when needed, increases the risk of infection and impacts the resident's dignity.

Sources: Room checks and Interview. [s. 89. (1) (a) (i)]

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 residents' linens are changed at least one a week and more often as needed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when receipt of a written complaint with respect to a matter under section 24 of the Act , a copy of the complaint was submitted to the Director along with a written report documenting the response the licensee made to the complainant.

The Administrator and DOC confirmed that the SDM of resident #001 had voiced concerns related to care of resident at the home, which continued for longer than a 24 hour period. The SDM informed the home that they did not want to speak to them further that they were going to call the Corporate Office. DOC confirmed that the SDM's complaint was not submitted to the Director.

The SDM of resident #001 confirmed that a few weeks after the residents death they telephoned the Corporate office to express their concerns, including allegations of neglect. SDM was informed by Regional Director (RD), that an investigation had been concluded at the home. The SDM stated that they had been informed by the RD that there was no evidence that the home was neglectful in the resident's care.

The RD confirmed that a complaint had been received at Corporate Office. The RD stated that the SDM had been called and their concerns were expressed, they informed the SDM that an investigation into the situation would be completed. The RD confirmed that they had contacted the SDM to provide them with the outcome of the investigation. The RD confirmed that the complaint and outcome, had not been forwarded to the Director. Failing to submit a copy of a complaint received related to matter under section 24 of the Act, diminishes transparency related to abuse in the home.

Sources: clinical health records for resident #001 and Interviews. [s. 103. (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 by ensuring that when the home receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who require assistance with eating are only served a meal when someone is available to provide assistance.

RPN #109 confirmed that the unit was short one staff and that a meal was late, staff were running to complete care and it was very hectic on the unit. Resident #010 and #011 were provided their soup and assistance was provided 8 minutes later. The main course was served to the residents while staff were still assisting with soup. Assistance with the main course was provided 5 minutes later for resident #010 and 10 minutes later for resident #011. Failing to provide assistance to residents at meals, when food is served, decreased the enjoyment of meals being consumed by the residents.

Sources: observation of meal service, Interview with staff. [s. 73. (2) (b)]

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Issued on this 21st day of October, 2021

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

Original report signed by the inspector.