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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 9, 2016	2016_289550_0035	006456-16, 008209-16, 008946-16, 020401-16	Critical Incident System

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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

JOANNE HENRIE (550), LINDA HARKINS (126)

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): September 21, 22, 23, 26, 29, 30, October 3, 4 and 5, 2016.

Logs #019415-16, #020654-16 and #008209-16 are related to three critical incidents the home submitted related to the allegations of abuse of residents, logs #008946-16 and #020401-16 are related to two critical incidents the home submitted related to a missing resident, and log #006456-16 is related to a critical incident the home submitted related to an unexpected death of a resident .

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several residents and family members.

In addition, the inspectors reviewed resident health care records and critical incident reports. The inspectors also observed resident care and services and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **6 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	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. 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 :

. The licensee has failed to ensure that the plan of care for resident # 006 set out clear directions to staff and others who provide direct care to the resident.

Related to Log #008946-16.

Resident #006 was admitted to the home in 2014 with multiple medical condition. Resident # 006 is dependent for care and requires total assistance from staff for mobilization in a wheelchair. Resident # 006 is able to communicate to others by verbally expressing himself/herself. The nursing staff indicated that the resident' speech is slow but he/she can make himself/herself understood.

On a specific date, Personal Support Worker (PSW) # 101 came to the nursing station with resident # 006 and informed Registered Nurse (RN) # 102 that resident disclosed to her sexual abuse. Resident # 006 told the PSW that his/her friend was sexually touching him/her and taking pictures with a cellular phone without the resident's consent. Resident # 006 indicated that this occurred on approximately ten occasions. Resident # 006 was upset at PSW # 101 as he/she did not want her to inform the RN. The Police and the Ministry of Health and Long Term Care were notified. Resident # 006 refused to talk to the Police officers when they visited him/her that evening.

On two separate occasions, Inspector # 126 tried to speak with the resident but the resident did not want to speak to the inspector.

On September 28, 2018, Inspector # 126 interviewed PSW#101 and RN # 102 regarding the incident of sexual abuse. PSW# 101 indicated that resident # 006 told her about the incident and was upset at her for sharing the information. PSW# 101 indicated that resident # 006 still wants to see his/her specific friend as he/she is the only support the resident has. PSW# 101 and RN # 102 indicated that since the incidents the specific friend can only visit resident # 006 in public areas, he/she is not allowed to go in the resident's room and if he/she takes the resident outside, he/she needs to be in a public area and cannot stay more than fifteen minutes at a time. If they do not return within the fifteen minutes, staffs have been instructed to go get resident # 006 and bring him/her back to the floor.

On September 29, 2016, Inspector # 126 interviewed RPN # 103 who indicated that the specific friend was not allowed to visit resident # 006 in his/her room. She indicated that

he/she can only visit the resident in a public area of the home and also when he/she brings the resident outside that his/her time was restricted. RPN # 103 printed the most recent plan of care and noticed that the restrictions related to the resident's specific friend were not documented on the plan of care and were not providing clear directions to staff. [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 written plan of care for resident #006 is reviewed and revised, to provide clear directions to staff regarding visitations restrictions for a specific visitor are documented, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 44 in that the licensee has failed to ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of the residents.

Related to Log #019415-16.

This is specifically related to the availability of pagers for nursing staff, which are connected to the resident-staff communication and response system, and which directly notify nursing staff when a call for assistance has been made.

On a specific date in 2016, it was reported to the Director of Care by resident #002 and a member of his/her family that the resident had to wait a long time to have his/her call answered whenever he/she used the call bell. Upon investigation by the Director of Care, it was reported by a PSW and discovered by the Director of Care that many of the pager's did not have batteries in them therefor had not been functional for a while.

On September 29, 2016, during the course of this inspection, Inspector #550 observed that two PSWs on the 2nd floor did not have pagers in their possession. PSW # 107 indicated to the inspector that there was no pager available for her to take at the beginning of her shift and PSW #109 indicated she forgot to take a pager when she started her shift that morning. Later that same day, it was observed by the inspector that PSW #109 was able to get a pager for herself but there was still no pager available for PSW #107.

During an interview, RN #106 indicated to the inspector that they usually have one pager available for each of the eight PSWs working on the floor plus two extra pagers. When she looked into the pager bin where the pagers and extra pagers are kept, she observed that the bin was empty adding that sometimes PSWs forget to return the pagers at the end of their shift and go home with them. The RN indicated to the inspector that PSWs have to sign ''out'' a pager when they take one at the beginning of their shift and sign it back ''in'' when they return the pager at the end of their shift. Both the inspector and the RN reviewed the pager binder and observed that the last sign ''in'' and ''out'' sheet was dated August 1, 2016. [s. 44.]

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 pagers, which are connected to the resident-staff communication and response system, are available to each nursing staff providing direct care to residents in the home, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair (excluding the residents' personal aids or equipment.)

Related to Log #019415-16

This home uses pagers as their communication and response system where the pager will alert the PSWs when a resident activates the call bell. By activating the call bell, this notifies PSWs via the pagers that this resident requires assistance.

On a specific date in 2016, it was reported to the Director of Care by resident #002 and a member of his/her family that the resident had to wait a long time to have his/her call answered whenever he/she used the call bell. Upon investigation by the Director of Care, it was reported by a PSW and discovered by the Director of Care that many of the pager's did not have batteries in them therefor had not been functional for a while.

On September 29, 2016, Inspector #550 observed that PSW #108 had a pager and upon the inspector's verification for functionality, it was observed that the pager was not working. The PSW indicated that the battery must have expired and proceeded to the nursing station to replace it.

The Director of Care indicated to the inspector that it is her expectation when a PSW takes a pager that they make sure it is functional but other than signing the pagers "in" and "out" in the pager binder, the home does not have procedures in place to ensure that their pagers are functional and kept in a good state of repair. The DOC further indicated that when a pager is not functioning properly, staffs are expected to immediately report any deficiencies to the registered nurse. Extra batteries are kept at each nursing station and are available to all staff.

As evidenced above, the licensee does not have procedures developed and implemented to ensure that the pagers used to alert staff when a resident requires assistance are kept in a good state of repair. [s. 90. (2) (b)]

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 procedures are developed and implemented to ensure that pagers used to alert PSWs when a resident requires assistance are kept in a good state of repair, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted:
19. Every resident has the right to have his or her lifestyle and choices respected.

Related to Log #008209-16.

Resident # 007 was admitted to the Home with several diagnoses. Resident # 007 ambulates independently with a walker

On two specific dates in 2016, the home submitted Critical Incident report (CI) to the Director, related to resident # 007, missing for more than three hours. These are the incidents:

On a specific date, resident #007 was observed walking toward a specific road and when asked by a nursing staff to come back to the home, he/she refused. Because the bus driver refused to take the resident on the bus, resident #007 walked to his/her friend's place. When resident # 007 returned to the home he/she was very upset and indicated

that he/she would leave the building and was more agitated. The physician was called and resident #007 was sent to the hospital. The resident was assessed at the hospital and was sent back the home in the early morning by bus. A sitter was arranged for 72 hours as supplementary staffing for one on one with the resident.

On another specific date, resident # 007 left the Home to go to his/her friend's house. The friend called the home to let them know that resident # 007 was at his/her place. The friend called back informing staff that the resident was on his/her way back to the home by taxi. Resident # 007 returned to the home without any injuries. It was noted in the CI, under the outcome/current status that resident # 007 was not happy that a wander guard bracelet was applied. Resident # 007 indicated that he/she was not a child and he/she should be allowed to go out whenever he/she wants. The resident also indicated that he/she is young and he/she cannot be kept in prison by preventing him/her from going to the front. Resident # 007 also stated that he/she was going to go out whenever he/she wanted to. Hourly checks were initiated to monitor the resident's whereabouts.

The morning of September 27, 2016, Inspector # 126 met with resident #007 in his/her room. Resident #007 was observed to be sitting up on the bed. Inspector # 126 informed him/her about the purpose of the visit related to his/her history of elopements in two specific months in 2016. Resident #007 indicated that these were not elopements because he/she never had the intention of not returning to the home. He/she indicated that he/she went to see a friend and that he/she is well aware of where he/she lives. The resident indicated "this is my home and I really like it here, the thing that upset me is that I feel that I am in a prison because they won't let me go out and they won't let me see my friend. I feel that everyone one here are making those decisions for me." Resident # 007 explained to Inspector #126 his/her past life habits and indicated that now he/she is doing much better and he/she is able to make better choices. He/she indicated that he/she was able to maintain healthy external relationships.

Resident # 007 is alert and oriented and was able to give the address of Extendicare Laurier Manor. Discussion held about risk of crossing the street, resident # 007 indicated that he/she crosses the street at the intersection and waits for the light. It is noted in the progress notes on a specific date and time that Activity Aid #100, observed resident # 007, alone, waiting for traffic lights to change and subsequently crossed the street. It is also noted in the progress notes on a specific date and time by the Social Worker that she witnessed resident # 007, returning to Laurier Manor from the front doors and asked the resident if he/she had gone across the street (to the convenience store) by himself/herself. The resident indicated stated that he/she did go unattended and does

not need to be accompanied because he/she is capable of going on his/her own. Resident #007 also indicated that he/she knows the bus route and how to take a bus and how to come back to the home.

Discussion held regarding the wander guard bracelets and resident # 007 indicated that he/she does not want to wear them because he/she should be allowed to go where ever he/she wants to go and that he/she is not a criminal. The resident also indicated to the inspector that he/she does not manage his/her finances, that it is the Public Guardian and Trustee (PGT).

At lunch time, on September 29, 2016, resident # 007 was observed on the main floor activity area having lunch with his/her friend. Resident # 007 was observed to be talkative and laughing and smiling at his/her friend. Inspector # 126 approached them to discuss about resident # 007's situation. Resident # 007 indicated that his/her friend is good to him/her; he/she is the one who pays for some of his/her things, brings him/her coffee and sometimes lunch. At the present time, he/she is only allowed to visit twice a week. Resident # 007 indicated that he/she would like to see him/her more frequently.

In reviewing resident # 007 progress notes for the period of seven months in 2016, it was noted that on several occasions he/she returned to the home without external assistance/negative outcome. On a specific date in 2016, the resident was sent to the hospital for an assessment. A note in the progress notes indicated that the resident came back from the hospital. He/she was noticed walking on the unit with his/her suitcase no paramedic present and no discharge paper was given to writer. Resident stated that he/she took the bus. Another note indicated "writer phone the hospital, they confirmed that the resident was release and given bus tickets to come back home. No discharge paper was given to the resident, it was sent to the act team."

On a specific date and time, a note indicated "Charge-nurse called writer at 2130 that resident #007 was out in front of the building and has crossed the other side of the street. Writer went and met resident in one of the stores as he/she was coming out. He/she was not happy that somebody came to look for him/her. He/she wanted to know why he/she cannot be allowed to go out when he/she wants. He/she said he/she is mature enough and that he/she is capable of making his/her own personal care decisions.

On a specific date and time, "Resident seen by office staff going out to the store across the street-when resident returned Registered Nurse (RN) spoke with him/her. Resident stated that he/she goes every day. RN reminded resident that he/she is not to go out on

his/her own. Resident stated to RN that he/she does not care "

On a specific date and time, "Resident went out to the corner store, unattended. Writer saw resident crossing the road. Writer asked him/her to come back and he/she refused. Resident stated that everybody knows that he/she has been going to the corner store and he/she will go as he/she pleases."

On a specific date and time, "Resident went across the road, with no staff supervision. Laurier manor staff went to get resident back to his/her room." There is also documentation of several discussions with resident # 007, the care team and the Power Of Attorney for a possible admission to a secure unit, restricting him/her from going out on his/her own and restrictions for his/her friend to visit. Resident # 007 wishes to be able to go out and see his/her friend. Resident # 007 stated that Laurier Manor is his/her home, the only home he/she has and that he/she does not want to move.

Inspector # 126 interviewed several staff regarding actual risk that was observed for resident # 007 not to have the right to go out. At this time, staff could not identify any current risk issues or incidents where the resident placed himself/herself at risk since his/her condition has improved.

At the present time, resident # 007 indicated to several staff and to Inspector # 126 that he/she can make his/her decisions to go out and to see his/her friend. He/she indicated to Inspector # 126 that he/she is in a good state of mental health and that he/she is aware that his/her past history made him/her make wrong choices. The resident's lifestyle and choices are not being respected by the home. Resident # 007 understands that if his/her condition changes that the home/physician/ Power of Attorney would implement interventions to ensure his/her safety. [s. 3. (1) 19.]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Related to Log #020654-16.

On a specific date in 2016, a CIS (crtical incident system) report was submitted to the Director reporting an alleged incident of physical abuse to resident #005 by PSW #111. The incident was investigated by the ADOC and the allegations were determined to be unfounded.

During an interview, the ADOC indicated to Inspector #550 she did not communicate the results of the abuse investigation to the Director as she was not aware she had to do so.

As such, the results of the abuse investigation were not reported to the Director. [s. 23. (2)]

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. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion.

Related to Log #020654-16.

On a specific date in 2016, a CIS report was submitted to the Director indicating that resident #005 had reported to RN #110 that PSW #111 was physically abusive and rough with him/her during care.

During an interview, the ADOC indicated that she investigated the alleged incidents of abuse and determined the allegations were unfounded. She indicated she did not notify the resident's substitute decision maker of the results of the alleged abuse investigation upon completion as she was not aware she had to do so.

As such, resident #005's substitute decision maker was not notified of the results of the alleged abuse investigation once it was completed. [s. 97. (2)]

Issued on this 10th day of November, 2016

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

Original report signed by the inspector.