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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 7, 2019	2019_583117_0044	013502-19, 014737-19, 014801-19	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 Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

LYNE DUCHESNE (117)

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 24, 25, 26, 2019

During this inspection the following critical incidents were inspected concurrently:
- Log #013502-19 a critical incident report (CIS) report #2665-000030-19 which relates to an incident that caused an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status
- Log #014737-19 a critical incident (CIS) report #2665-000035-19 which relates to an alleged incident of staff to resident abuse
- Log #014801-19 a critical incident (CIS) report #2665-000036-19 which relates to an alleged incident of resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a Registered Nurse (RN), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), and to several residents.

During the course of the inspection, the inspector reviewed several resident healthcare records, observed the provision of care and services of mobility devices and fall prevention devices and interventions, observed staff to resident interactions, reviewed the licensee's internal investigation reports.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care provided to the resident as specified in the plan (Log #013502-19)

Resident #001 is identified as being at risk for falls. The plan of care identifies that the resident is to have a bed alarm in place when the resident is in bed.

On September 24, 2019, it was observed that there were no bed alarms on resident #001's bed or in their room. Inspector #117 spoke with evening staff RPN # 105 and PSW # 104 who both verified the resident's plan of care and stated that the resident was identified to have a bed alarm when in bed and would ensure that this will be in place.

On September 25, 2019, at 0900 hours, Inspector #117 observed resident's room and noted that no bed alarm was present. Discussion held with PSW #106 who is resident #001's main caregiver. The PSW #106 said that the resident did not have a bed alarm in place when they provided morning care to the resident. RN #108 said that the resident's plan of care does specify the need for the bed alarm to be in place as a fall prevention intervention. A further review of the resident's plan of care and the PSW Point of Care (POC) system that identifies care to be provided to the resident, with RN #108 and PSW # 106 showed that the plan of care does identify the use and application of the bed alarm but that the POC system does not have this information. Both staff members said that if the use of the bed alarm is not in the POC system, non-registered nursing staff would not apply the bed alarm.

Discussion held with the administrator related to the application of the bed alarm and the discrepancy between the resident's plan of care and POC system. The administrator said that staff are to follow the resident's plan of care and that the bed alarm should have been applied as specified in the plan. [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 to ensure that the care set out in the plan of care provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 7th day of October, 2019

[redacted]

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

Original report signed by the inspector.