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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
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Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
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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 3, 2016	2016_391603_0016	028203-15, 006417-16, 007869-16, 008262-16, 008540-16, 009316-16	Complaint

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 TIMMINS
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

SYLVIE LAVICTOIRE (603), RYAN GOODMURPHY (638)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 25-28, 2016.

The following logs were completed during the inspection: five logs related to insufficient staffing; and one log related to abuse and neglect of a resident.

A Critical Incident Inspection #2016_391603_0017 and a Follow Up Inspection #2016_391603_0018 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, various home policies, procedures, programs, and staff education attendance records.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs),Housekeeping Staff, Behavioral Support Ontario (BSO) staff, Office Manager, Residents, and Family Members.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #638 reviewed four complaints reported to the Director which related to staffing concerns and alleged improper resident care.

Inspector #638 conducted a record review of the PSW staffing list for a 24 day period, which indicated that for 14 of the 24 days or 58 per cent of the time, the front line staff worked short at least two PSWs. During a concurrent review of the staffing list it was noted that two days later outside of the 24 day period, on a specific day, two of 18 PSWs were sick for a specific shift.

In an interview with Inspector #638, PSW #116 indicated that when the home was short staffed, staff (mainly PSWs) were reassigned to different home areas. On the above date, while short two PSWs, a third PSW was reassigned to shower duty (in addition to regular duties). This left three out of six home areas short with only two of the three PSWs to provide all resident assessed care needs.

Inspector #638 reviewed resident #009, 011, 012, 013, 014, 015, 016 and 019's health care records which indicated that each of these residents were on a pre-determined treatment schedule, which was to be completed at certain times throughout each shift.

a) Inspector #638 conducted a record review of resident #019's care plan which indicated that staff were to specifically care and assist the resident between 0700-0800, 0900-1000, 1300-1400, and 1600-1700 hours. In a concurrent record review, resident #012's care plan indicated that staff were to provide care and assistance to the resident between 0800-0900, 1100-1200, 1300-1400, and 1600-1700 hours.

Inspector #638 interviewed resident #012 in the afternoon of the day that two PSWs called in sick, who stated that they had not been assisted with their care need since the morning and had been waiting for "quite some time". During that same afternoon, Inspector #638 interviewed resident #019 who stated they had not been assisted with their care need since that morning care.

On that same afternoon, Inspector #638 interviewed PSW #116 who stated that resident #011, 012, 013, 014, 015 and 016 had not been cared for or provided assistance as per their care needs since their morning care, prior to breakfast. PSW #116 later indicated that staff were unable to follow the residents' specific care routines due to staffing

constraints, and that this was not acceptable. PSW #116 also indicated that staffing constraints was a trend within the home, and that a specific care was one of the first care practices not completed due to front line staffing shortages.

b) Inspector #638 reviewed resident #023's care plan which indicated that a specific transfer technique was required for transferring the resident.

In an interview with Inspector #638, resident #023 stated that care was delayed or extremely rushed whenever the home was short staffed. Resident #023 explained that there were times when staff were unable to transfer them until after lunch, due to staffing shortage and the needs of other residents on the unit. Resident #023 recalled that there had been times where they had asked to get up in the morning and was not able to be attended to, until after lunch (no specific dates were given).

Inspector #638 interviewed PSW #118 who explained that they were continuously short staffed and unable to provide all residents' assessed care needs. Further interview indicated that anytime the home was short staffed, the residents had to wait long periods of time for continence care or assistance with transferring needs.

c) Inspector #638 reviewed resident #022's care plan which indicated that staff were to provide specific care for the resident between 1000 and 1100 hours, in order to ensure comfort.

Inspector #638 observed resident #022 sitting in a specific chair from 0840 to 1140 hours. During this time, the resident was not checked or provided specific care as indicated in their care plan for at least three hours.

Inspector #638 interviewed PSW #117 who explained that the home was short staffed and that this had not provided enough time for all assessed resident care requirements. PSW #117 further explained that when short staffed, the first care requirements not completed were residents' toileting schedules. PSW #117 stated that this lack of care frequently caused residents who were continent to become incontinent, due to unavailable staff to toilet the residents as per their assessed needs.

Inspector #638 interviewed RN #114 who stated that it was the home's expectation to provide all residents' required care as laid out within the plan of care. RN #114 explained that resident #022 had not been cared for as per their care plan due to being short staffed one PSW on the unit.

In an interview with Inspector #638, the DOC confirmed that when the home was short staffed, the staffing mix was not always consistent with the residents' assessed care needs. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 9th day of November, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SYLVIE LAVICTOIRE (603), RYAN GOODMURPHY (638)
Inspection No. / No de l'inspection :	2016_391603_0016
Log No. / Registre no:	028203-15, 006417-16, 007869-16, 008262-16, 008540-16, 009316-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 3, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE TIMMINS 15 Hollinger Lane, Box 817, Schumacher, ON, P0N-1G0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Kelly Roy

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall develop and implement a management recruitment and retention committee that will meet on a regular basis, to address staffing shortage in order to ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents. The committee will have terms of reference, and maintain a list of attendees and minutes.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Inspector #638 reviewed four complaints reported to the Director which related to staffing concerns and alleged improper resident care.

Inspector #638 conducted a record review of the PSW staffing list for a 24 day period, which indicated that for 14 of the 24 days or 58 per cent of the time, the front line staff worked short at least two PSWs. During a concurrent review of the staffing list it was noted that two days later outside of the 24 day period, on a specific day, two of 18 PSWs were sick for a specific shift.

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In an interview with Inspector #638, resident #023 stated that care was delayed or extremely rushed whenever the home was short staffed. Resident #023 explained that there were times when staff were unable to transfer them until after lunch, due to staffing shortage and the needs of other residents on the unit.

Resident #023 recalled that there had been times where they had asked to get up in the morning and was not able to be attended to, until after lunch (no specific dates were given).

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In an interview with Inspector #638, the DOC confirmed that when the home was short staffed, the staffing mix was not always consistent with the residents' assessed care needs.

Although there was no previous compliance history related to this provision, there have been repeated related non-compliances including but not limited to the area of staffing.

The decision to issue this compliance order was based on the scope which was widespread, the severity which indicated a potential for actual harm.
(603)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 02, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 3rd day of November, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sylvie Lavictoire

Service Area Office /
Bureau régional de services : Sudbury Service Area Office