Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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 2, 2019	2019_655679_0026	017697-19	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 Timmins
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

MICHELLE BERARDI (679)

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): September 25-27, 2019.

The following intake was inspected upon during this Complaint Inspection:

- One complaint intake submitted to the Director related to staffing levels in the home.

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), residents and families.

The Inspector also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, complaint records, as well as relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 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. 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.

A Complaint was submitted to the Director outlining concerns with short staffing in the home.

In a telephone interview with the complainant they identified to Inspector #679 that the home has been working short Personal Support Workers (PSWs) for months and that resident care was affected.

In separate interviews with Inspector #679, PSWs #102, #103, #104, #105, RPN #107, RN #106 and RN #109 expressed that the home worked short staffed.

A) Inspector #679 reviewed the document "Extendicare Timmins Nursing Staff Complement" which identified that for each shift, each unit was to have a specific number of PSWs.

Inspector #679 reviewed a hand-written document provided by the DOC which outlined the staffing shortages in the home for the last two weeks of August and the first 17 days of September (a total of 30 days). The inspector identified the home worked short staffed PSWs on 22 dates, or 73 per cent of the time reviewed.

B) In a telephone interview with the complainant they identified that they had noticed prolonged call bells and that they have had to wait up to 30 minutes for someone to come to assist resident #001.

In interviews with residents #003 and #008 they identified that the home worked short staffed, and that sometimes they had to wait for their call bells to be answered.

In an interview with PSW #102 they identified that when the home was short staffed it takes them longer to respond to call bells.

In an interview with PSW #103 they identified that when the home was short staffed, sometimes residents would have to wait for their call bells to be answered as staff couldn't respond to them right away.

Inspector #679 reviewed the call bell records for specified dates and identified the following related to call bell wait duration:

- On a specified date (1430 hours to 2230 hours) a specified home area has one call bell duration of over 10 minutes.
- On a specified date (0630 hours to 1430 hours) a specified home area had three call bell durations of over 10 minutes.

C) In an interview with resident #003 they expressed that meal service had been affected because of short staffing, stating that meal service was to start at 0830 hours, but that they were not served until 0845 hours.

Inspector #679 observed a specified home area on September 27, 2019, at 0827 hours, and identified 12 residents in the dining room for the 0830 hours meal service.

Inspector #679 interviewed RN #106 on September 27, 2019, and they identified that the home was short a specific number of PSWs causing every floor to be short. RN #106 identified that the staffing shortage affects the snack pass, portering and meal times, and that the meal service on the specified home area started late.

D) Inspector #679 reviewed a document titled "Staffing Plan review" dated January 24, 2019. The document identified that there was some concern in regards to recruiting for part time PSWs at the time of the review.

In an interview with the DOC they identified that there were staffing challenges in the home. The DOC confirmed that the home was short a specific number of PSWs on September 27, 2019, and that the meal service on the specified home area was late. [s. 8. (1) (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 ensuring that there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent had an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A Complaint was submitted to the Director outlining concerns with short staffing in the home.

In a telephone interview with the complainant they identified to Inspector #679 that resident #001 had been found soiled.

Inspector #679 reviewed the electronic progress notes for resident #001 and identified a note which indicated that they had been found soiled.

Inspector #679 reviewed resident #001's care plan at the time of this incident which identified a plan to manage the resident's continence needs.

Inspector #679 reviewed the home's documentation related to the concern. The document identified that resident #001 had been found soiled.

Inspector #679 reviewed a document addressed to PSW #108 which identified that it was the staff's responsibility to ensure that all resident care was provided as per their plan of care.

In an interview with the DOC they identified that they received the concern regarding resident #001's care. The DOC identified that they reviewed the Point of Care (POC) documentation, care plan and spoke with the primary PSW who identified that resident #001 had been found soiled.

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 ensuring that each resident who is incontinent has an individualized plan to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred immediately reported the suspicion and the information upon which it was based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

A Memorandum titled "Clarification of Mandatory and Critical Incident Reporting Requirements" dated July 05, 2018, was sent to the Long-Term Care Home Licensees

and Administrators. This memorandum identified that "A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident".

A Complaint was submitted to the Director outlining concerns with short staffing in the home.

In a telephone interview with the complainant they identified to Inspector #679 that resident #001 had been found soiled.

Inspector #679 reviewed the electronic progress notes for resident #001 and identified a progress note outlining the alleged neglect.

Inspector #679 reviewed the Ministry of Long-Term Care's online reporting portal and could not locate a Critical Incident (CI) report related to this allegation of neglect.

In an interview with Inspector #679, PSW #104 identified that if they were notified of an allegation of abuse, they would report it forward to registered staff.

In an interview with Inspector #679, RN #106 identified that if they witnessed abuse or neglect, they would immediately remove the staff member from the area, and immediately report it to the Director of Care (DOC). RN #106 further identified that they had notified the DOC of the allegation of neglect.

In an interview with the DOC they identified that they follow the home's policy and the legislation for reporting abuse and neglect. Inspector #679 questioned if the home reported this allegation of neglect and the DOC identified that they did not submit a CI report. [s. 24. (1)]

Issued on this 3rd day of October, 2019

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

Original report signed by the inspector.