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

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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
Jun 19, 2018	2018_395613_0012	002823-18	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 York
333 York Street SUDBURY ON P3E 5J3

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

LISA MOORE (613), SYLVIE BYRNES (627)

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): May 17-18, 2018 and May 22-25, 2018.

A Follow Up Inspection # 2018_395613_0011 and a Critical Incident Inspection # 2018_616542_0013 were completed concurrently with this Complaint Inspection. Please see the additional reports for further findings of non compliance.

The following intake was completed during this Compliant Inspection:

One complaint regarding numerous concerns of the provisions of care.

During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs and the home's internal investigation files.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 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	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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A complaint was submitted to the Director indicating concerns of the provisions care for resident #003.

Inspector #627 interviewed resident #003's Substitute Decision-Maker (SDM), who reported that they had concerns that the resident was admitted to the home due to their fall risk and the inability to perform a specific activity of daily living, and this was not reflected in their care plan. They further stated that they had brought their concerns forth to the home.

A review of the admission care plan identified under the focus for falls that resident #003 was at a specific risk for falling and was able to perform, and be left unattended, for a specific activity of daily living.

A review of the Scott Fall Risk completed by the registered staff, and the physiotherapy assessments specific to fall risk for resident #003 completed at the time of admission, both indicated that the resident was a different specific fall risk than identified on the admission care plan.

A review of the Resident Assessment Instrument for Home Care (RAI-HC), submitted by the Community Care Access Center (CCAC), dated prior to resident #003's admission to the home, indicated that the resident had a history of falls and a specific safety device was used to maintain their safety due to their inability to perform a specific activity of daily living.

A review of the Interdisciplinary Team Care Conference notes indicated that the family had been requesting for three months since admission a safety device for the resident.

During an interview with RN #102 they reviewed the Scott Fall Risk Screen completed on admission and acknowledged that some things were missed in the admission assessment which would have changed the fall level risk for resident #003 and provided for more support with activity of daily living in their care plan. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the substitute decision maker (SDM), if any, and the designate of the resident/SDM were provided the opportunity to participate fully in the development and implementation of the plan of care.

A complaint was submitted to the Director indicating that resident #003's care plan had six amendments for which the SDM had not been involved or given authorization.

Inspector #627 interviewed resident #003's SDM, who indicated that there had been multiple changes made to the care plan that they were not made aware of. Resident #003's family member provided those examples to the Inspector:

- changes to bowel continence interventions that were not discussed with the SDM;

- removing specific care interventions related to identification of an infection that the SDM felt were important to prevent the specific infection;

-changes to the goal and interventions for the resident's mobility status; and,

-specific interventions requested by the family for resident #003's urinary continence management were removed from the care plan without the SDM's input.

During an interview with resident #003's SDM, they stated that they had requested to be notified of any changes in the resident's care plan on multiple occasions, as they wanted

to take part in the development, implementation, review and revision of the care plan as it was their right as the SDM, as stated in the Long-Term Care Act. The SDM stated that the Administrator had replied to them that they seemed to have different interpretations of the legislation, and that the family were to be provided with a copy of the care plan one week prior to resident #003's care conference.

A review of resident #003's electronic progress notes failed to identify any entry indicating that the aforementioned changes had been discussed with resident #003's SDM.

During an interview with RN #102, they acknowledged that the SDM should have been made aware of the changes to resident #003's care plan. RN#102 further stated that registered nursing staff were aware of the need to call the SDM when care plan changes were made; however, other disciplines such as other interdisciplinary team members continued to update the care plan. This concern was brought up during a care conference with resident #003's SDM and a form was developed to ensure that other departments were indicating, on the form, the changes done to the care plan. The RN was then responsible to follow up with the SDM and notify them of the changes.

During an interview with the Administrator, they stated that they had struggled with notifying resident's SDM of changes to the written plan of care and had struggled to meet the expectation of resident #003's SDM. They further stated that a form had been developed as a result of the home's last Resident Quality Inspection, and this had been helpful to keep track of the changes for resident #003's plan of care from all disciplines, which were reflected in the written care plan. [s. 6. (5)]

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and to ensure that the substitute decision maker (SDM), if any, and the designate of the resident/SDM are provided the opportunity to participate fully in the development and implementation of the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A complaint was submitted to the Director in February 2018, in regards to a lack of communication from the home regarding complaints.

Inspector #627 reviewed the complaint report which indicated that resident #003's SDM submitted four written complaints and one verbal complaint to the home and the home had not responded them.

During an interview with resident #003's SDM, they indicated that they had submitted written complaints to management in April 2017, regarding unnecessary noise and interactions; August 2017, regarding medication dispensing, October 2017; in regards

to medical incompetence and September 2017, regarding staff shortages. The SDM provided the Inspector with a copy of the, "Extendicare Complaint Investigation" forms, which they had documented their complaints on. Resident #003's SDM stated that they had been told by the Administrator and the DOC that if the concerns could be dealt with, it was not considered a written complaint. Resident #003's SDM stated that they were aware that all written complaints were to be submitted to the Director and that they doubted that the home had submitted their written complaint to the Director.

A review of the home's policy titled "Complaints and Customer Service", #RC-09-01-04, last reviewed in 2017, indicated that written complaints included written notification in any format, including anything handwritten such as letters, notes, correspondence, e-mails, facsimile documents and text messages and to ensure that timelines for responding to verbal/written complain were followed and that the documentation was forwarded to provincial, regional, local heath and or other authorities, as required.

During an interview with the Administrator, they stated that resident #003's SDM had come forth with concerns which had been addressed verbally. The Administrator had conversations with the SDM to inform them that they were not to use the form that they had used to submit a written complaint, as this was an internal document. The Administrator stated that resident #003's SDM had stated that those written complaints were not formal complaints and for this reason they had not been submitted to the Director.

During an interview with the DOC, they stated that the home's policy indicated that all written complaints were to be forwarded to the Director; however, they had not felt that the tool resident #003's SDM had developed to bring forth complaints constituted a formal written complaint. They treated them as verbal complaints. The DOC further stated that they had not treated correspondence brought forth as a written complaint unless they were directed by the complainant to do so. [s. 22. (1)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that complaints be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint.

A complaint was forwarded to the Director, from resident #003's family member alleging that written complaints brought forth to the administration were being dismissed. Please refer to WN #1 for further details.

A review of the home's policy titled "Complaints and Customer Service", #RC-09-01-04, last updated April 2017, indicated that in Ontario, complaints/concerns brought forward must be investigated, resolved (where possible), and a written response signed by the Administrator provided to the complainant within 10 days of receipt.

During an interview with the DOC, they stated that they had met with resident #003's SDM and they had verbalized that they had not wanted the concerns brought forward as written complaints. The DOC stated that they had considered the medication incident written complaint as it may have been a medication error, in terms of reporting and tracking. The concern was brought forth on August 2017, and a response was sent in writing eight months later.

During an interview with the Administrator, they stated that when resident #003's SDM submitted the complaints, they had been verbally responded to. They further stated that they had missed closing the loop by not responding in writing. [s. 101. (1) 1.]

Issued on this 26th day of June, 2018

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

Original report signed by the inspector.