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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 27, 2017	2017_670571_0015	019230-17	Resident Quality Inspection

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 PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

PATRICIA MATA (571), BAIYE OROCK (624), SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 2, 3, 4, 5, 6, 11 and 12, 2017.

In addition, the following Critical Incident logs were inspected:
related to staff to resident abuse - 020830-17, 020835-17, 020841-17
related to injury resulting in a fracture- 020492-17
related to a fire in the home - 023057-17
The following complaint logs were inspected:
related to resident rights and safety - 022629-17

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behaviour Supports Ontario (BSO) PSW, Activity Aide (AA), residents and SDM's.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #022's was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Re: Log # 023057-17 and 022629-17:

A Critical Incident was reported to the Director on a specified date regarding a specific incident.

A review of the progress notes for resident #022 for a specified period of approximately eight months, indicated that resident #022 demonstrated an identified responsive behaviour. The following interventions were put into place for the identified responsive behaviour:
-Specified date-intervention one was implemented to address resident #022's identified responsive behaviour
-11 days later-interventions one was reviewed with the resident
-approximately eight weeks after the preceding date, the resident demonstrated the identified responsive behaviour; intervention one was discontinued and intervention two was implemented
-the next day after implementation of intervention two, the resident continued to demonstrate the identified responsive behaviour
-three days after the previously mentioned date, the resident was assessed; intervention two for the identified responsive behaviour remained in place
-the next day, intervention two was discontinued for the identified responsive behaviour; intervention one was re-implemented; resident #022 agreed to the re-implementation of intervention one
-twelve days later, resident #022 continued to demonstrate the identified responsive behaviour; no new interventions were implemented
-nineteen days after the previous date-intervention one was discontinued and intervention three was implemented
-for a specified three month period, there was no documentation to indicate that resident #022 was demonstrating the identified responsive behaviour
-on a specified date, resident #022 began to again demonstrate the previously identified responsive behaviour
-the next day, intervention three was altered and resident #022 agreed to the altered intervention

A review of the clinical health care records for resident #022 for an identified period of time was completed. Resident #022 demonstrated responsive behaviours that indicated the implemented interventions were ineffective on at least twenty-seven occasions.

In addition, because the plan of care for resident #022's identified responsive behaviour had been ineffective, several residents were negatively impacted.

In an interview with Inspector #571, PSW #127 indicated that she had expressed concern about resident #022 continuing to demonstrate the identified responsive behaviour despite the implementation of the interventions.

In an interview with Inspector #571, RPN #124 indicated that it was difficult to always implement the interventions for specified reasons. In separate interviews with Inspector #571, the Administrator, DOC and ADOC indicated that the plan of care was not reviewed and revised for resident #022's when the care set out in the plan had not been effective.

The licensee failed to reassess, review and revise resident #022's plan of care related to a specified responsive behaviour when the care set out in the plan had not been effective.

Additional Required Actions:

CO # - 901 was served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 abuse of a resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Re: Log #020841-17:

A Critical Incident Report (CIR), was submitted to the Director for an incident of alleged staff to resident verbal abuse. PSW #102 reported to the Director of Care (DOC) that she had witnessed PSW #128 yell at resident #026.

In an interview with Inspector #571 on October 13, 2017, the DOC indicated that although she had immediately started an investigation into the allegations of staff to resident abuse, she did not immediately report the allegations to the Director and reported the incident eight days late.

Re: Log #020835-17:

A CIR was submitted to the Director for an incident of alleged staff to resident verbal abuse. PSW #126 reported to the DOC that on a specified date, PSW #126 had

witnessed PSW #128 being verbally and physically abusive towards resident #008.

In an interview with Inspector #571 on October 13, 2017, the DOC indicated that although she had immediately started an investigation into the allegations of staff to resident abuse, she did not immediately report the allegations to the Director and reported the incident one day late.

Re: Log #020830-17:

A CIR was submitted to the Director for an allegation of alleged staff to resident verbal abuse. On a specified date, resident #025 reported to the DOC that four days earlier, PSW #128 had been verbally abusive.

In an interview with Inspector #571 on October 13, 2017, the DOC indicated that although she had immediately started an investigation into the allegations of staff to resident abuse, she did not immediately report the allegations to the Director, but rather two days late.

The licensee failed to ensure that three allegations of alleged staff to resident abuse were immediately reported to the Director. [s. 24. (1)]

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 by ensuring that when the licensee has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, the licensee shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

Inspector #570 reviewed the Residents' Council meeting minutes and the licensee`s written responses to concerns and recommendations raised by Residents 'Council for a specified four month period. The following was noted:
- Residents brought forward a recommendation at a specified meeting; a written response from the administrator was provided 21 days later.
- Residents raised two concerns at a meeting on a later date; a written response was provided over a month later for one concern and there was no written response regarding the second concern.
-During the same meeting residents brought forward two recommendations; a written response was provided over a month later
- During another meeting, residents raised a concern; a written response was provided 13 days later.

On October 5, 2017, during an interview, the program, manager who was assigned as assistant to the Residents' Council indicated to Inspector #570 that concerns and recommendations brought forward at the council meeting were included in the minutes of the meeting. The program manager further indicated that the minutes were forward to the management team via e-mail on the same date or the following date of the meeting; once a written response is received, it is forwarded to the executive members of the Residents' Council and posted in residents' home areas. The program manager indicated written responses to the resident council for concerns or recommendations brought forward during the aforementioned four month period were not within 10 days.

On October 6, 2017, during an interview, the Administrator indicated to Inspector #570 that his usual practice was to respond to concerns and recommendations in writing within ten days of receiving the Residents' Council meeting minutes. The Administrator confirmed that written responses for concerns and recommendations for the previously mentioned meetings were not provided in within ten days. [s. 57. (2)]

Issued on this 14th day of November, 2017

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) :	PATRICIA MATA (571), BAIYE OROCK (624), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2017_670571_0015
Log No. / No de registre :	019230-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 27, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE PORT HOPE 360 Croft Street, PORT HOPE, ON, L1A-4K8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jeff Donovan

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

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

Order # / Ordre no : 901

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Order / Ordre :

The licensee is ordered to:
1) Reassess resident #022's plan of care to identify and implement effective interventions to ensure the resident does not demonstrate the identified responsive behaviour. These interventions must include but are not limited to: which staff are responsible for monitoring the resident; what exactly staff are to monitor; where staff are to monitor the resident; how often, how and where the assessment of interventions are to be documented; and if resident #022 does demonstrate the identified responsive behaviour, what interventions, other than the interventions which were not effective in the past, are to be implemented to ensure the safety of all residents.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #022's was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Re: Log # 023057-17 and 022629-17:

A Critical Incident was reported to the Director on a specified date regarding a specific incident.

A review of the progress notes for resident #022 for a specified period of

approximately eight months, indicated that resident #022 demonstrated an identified responsive behaviour. The following interventions were put into place for the identified responsive behaviour:
-Specified date-intervention one was implemented to address resident #022's identified responsive behaviour
-11 days later-interventions one was reviewed with the resident
-approximately eight weeks after the preceding date, the resident demonstrated the identified responsive behaviour; intervention one was discontinued and intervention two was implemented
-the next day after implementation of intervention two, the resident continued to demonstrate the identified responsive behaviour
-three days after the previously mentioned date, the resident was assessed; intervention two for the identified responsive behaviour remained in place
-the next day, intervention two was discontinued for the identified responsive behaviour; intervention one was re-implemented; resident #022 agreed to the re-implementation of intervention one
-twelve days later, resident #022 continued to demonstrate the identified responsive behaviour; no new interventions were implemented
-nineteen days after the previous date-intervention one was discontinued and intervention three was implemented
-for a specified three month period, there was no documentation to indicate that resident #022 was demonstrating the identified responsive behaviour
-on a specified date, resident #022 began to again demonstrate the previously identified responsive behaviour
-the next day, intervention three was altered and resident #022 agreed to the altered intervention

A review of the clinical health care records for resident #022 for an identified period of time was completed. Resident #022 demonstrated responsive behaviours that indicated the implemented interventions were ineffective on at least twenty-seven occasions.

In addition, because the plan of care for resident #022's identified responsive behaviour had been ineffective, several residents were negatively impacted.

In an interview with Inspector #571, PSW #127 indicated that she had expressed concern about resident #022 continuing to demonstrate the identified responsive behaviour despite the implementation of the interventions.

In an interview with Inspector #571, RPN #124 indicated that it was difficult to always implement the interventions for specified reasons. In separate interviews with Inspector #571, the Administrator, DOC and ADOC indicated that the plan of care was not reviewed and revised for resident #022's when the care set out in the plan had not been effective.

The licensee failed to reassess, review and revise resident #022's plan of care related to a specified responsive behaviour when the care set out in the plan had not been effective.
(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 10, 2017

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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of October, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

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