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 # / Registre no	Type of Inspection / Genre d'inspection
Dec 5, 2016	2016_215123_0012	020704-16, 029354-16	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 HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

MELODY GRAY (123)

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): October 5 and 6, 2016

Concurrent inspections: 020704-16 related to alleged physical abuse and 032971-16 related to responsive behaviours

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSWs), registered staff, the Behaviour Services Ontario (BSO) nurse, the Assistant Director of Care (ADOC), the Director of Care (DOC), the Administrator and the Corporate Nursing Consultant. The home's records and the resident's record were reviewed. Staff and residents were observed.

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

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home as evidenced by:
The records of residents #001 and #002 were reviewed. It was noted that on an identified date in September 2016, Personal Support Worker (PSW) #100 witnessed resident #002 in resident #001's room inappropriately touching resident #100 without their consent. The incident also resulted in physical injury to resident #001. Resident #001 was noted to have cognitive impairments and as being unable to give consent. There was no noted history of inappropriate touching found in the record of resident #002. The home's records were reviewed and contained information as above.
The home's staff including PSW #100, the Assistant Director of Care (ADOC) and the Director of Care (DOC) were interviewed and they confirmed that resident #001 was inappropriately touched by resident #002 and that resident #001 did not consent to the act. They also reported that resident #002 had no known history of inappropriate touching. [s. 19. (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 to ensure that all residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the responsive behaviour plan of care based on an interdisciplinary assessment of the resident that included: any mood and behaviour patterns, including wandering; any identified responsive behaviours; any potential behavioural triggers and variations in resident functioning at different times of the day as evidenced by:

The record of resident #002 was reviewed including: the progress notes from March 2016 to October 2016; the care plans dated April 2016 and October 2016 and the kardex. Progress notes documentation indicated that during this period the resident exhibited identified responsive behaviours. The care plan dated April 2016 did not contain any information related to the resident's identified responsive behaviours. No potential behavioural triggers were identified in the care plan.
The care plan dated October 2016 was reviewed and it included some of the identified responsive behaviours created in September 2016 and initiated in June 2016. The care plan did not include a focus related to some identified behaviours and there were no triggers identified.
The home's records were reviewed and it was noted that on an identified date in September 2016, resident #002 entered the room of resident #001 and inappropriately touched them.
The Assistant Director of Care (ADOC) and the DOC were interviewed and confirmed that the care plan dated April 2016 was the care plan being used by the staff to provide care to resident #002 at the time incident occurred and that the care plan was reviewed and revised after the incident took place and was dated October 2016. They also confirmed that the plan of care was not based on an interdisciplinary assessment of: the mood and behaviour patterns, including wandering and any identified responsive behaviours and any potential behavioural triggers. The DOC also confirmed that no triggers were identified as above. [s. 26. (3) 5.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions as evidenced by:
The family member of resident #001 reported that on and identified date in November 2016, resident #002 was seen on the same floor of the home area of resident #001. Resident #002 was accompanied by the Personal Support Worker (PSW). No interaction occurred between the two residents. Due to a previous incident in September 2016 involving resident #001 and #002, the home determined that resident #002 was to be kept away from the floor where resident #001 resides.
The Director of Care (DOC) was interviewed and confirmed that on the identified date in November 2016, resident #002 was accompanied by a PSW to the floor where resident #001 resides and resident #002 was not to be on that floor. That information was included in the record of resident #002 including in the kardex and was also communicated to the staff at the start of each shift. The PSW involved worked with resident #002 previously as the home uses consistent staff to work with that resident.
The DOC confirmed that the home had taken steps to minimize risk of potential harmful interactions between residents #001 and resident #002 by identifying and implementing the interventions, however the interventions were not implemented on an identified date in November 2016 as resident #002 was accompanied by a PSW to the floor where resident #001 resides. [s. 54. (b)]

Issued on this 8th day of December, 2016

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

Original report signed by the inspector.