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**

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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 |
|---|---|---|---|
| Feb 2, 2017 | 2017_556168_0002 | 034439-16 | 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 HALTON HILLS
9 Lindsay Court Georgetown ON L7G 6G9

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

LISA VINK (168), CAROL POLCZ (156), CATHY FEDIASH (214), GILLIAN TRACEY (130), LESLEY EDWARDS (506), YULIYA FEDOTOVA (632)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): January 16, 17, 26, 27, 30 and 31, 2017.**

**The following inspection were completed concurrently with this RQI.**
**Critical Incident Submissions (CIS):**
**020120-16 - critical incident related to reporting certain matters to the Director and transferring and positioning techniques.**
**011641-16 - critical incident related to falls prevention and management.**
**022455-15 - critical incident related to reporting certain matters to the Director and transferring and positioning techniques.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Assessment Instrument (RAI) Coordinator, Program Manager, Nutrition Manager, housekeeping and maintenance staff, Registered Dietitian (RD), cook/dietary aid, Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.**

**During the course of the inspection, the inspector(s): toured the home, observed the provision of care and services, reviewed relevant documents including but not limited to: clinical records, policies and procedures and meeting minutes.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Residents' Council**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

**7 WN(s)**
**5 VPC(s)**
**0 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,**
**(a) the planned care for the resident; 2007, c. 8, s. 6 (1).**
**(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).**
**(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).**

**s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A. The written plan of care for resident #100 indicated under the focus statement, that they required the personal assistive services device (PASD) of half left bed rail in upright position. The same plan indicated, under the interventions heading that the resident required the PASD of a left and right half bed rail in the upright position to be used for and as a hold device and to aid the resident in and out of bed.
The resident's bed was observed on an identified date in 2017 and had the right half rail

engaged and the left half rail in the upright assist position.
Interview with the ADOC confirmed that the written plan of care did not provide clear direction to the staff who provided care to the resident related to bed rail use. (Inspector #130).

B. The plan of care for resident #101 identified, under the focus statement for PASD, that they used one full right and one half left bed rail when in bed to assist with turning and repositioning as well as right and left quarter bed rails to assist with repositioning; and the focus statement for bed mobility noted that the resident was to have both left and right short bed rails when in bed for safety.
The resident was observed in bed on an identified date in 2017, with a full raised padded rail on the right side of the bed and a half raised rail on the left side of the bed. Interview with the resident, while in bed, verified that they used the rails for turning and repositioning and for comfort.
Interview with RPN #601, following a review of the plan of care, verified that the plan did not give clear direction to staff who provided care related to rail usage and that they had modified the plan to provide consistent direction and terminology to staff. (Inspector #168)

C. The plan of care for resident #101 identified that they were incontinent of bowel and bladder, used incontinent products for containment and were to be changed regularly, which was confirmed with PSW staff #600, #608 and #609.
The plan did not provide clear direction. The focus statement for elimination/toileting needs identified that the resident used a large sized brief, a green brief on days/evenings/nights with purple briefs as extra for each shift. The focus statement for bowel incontinence noted that they used a regular green and purple brief as well as a purple medium brief during the day/evening shift and a green brief during the night; and under the focus statement for urinary incontinence it identified the use of a purple medium brief during the day and that evenings and nights was a green night brief.
A review of the Tena binder, Resident Profile Worksheet identified that the resident used a beige brief on days and evenings, and as an extra, as well as a green large/extra large brief at night.
Observation of the resident's room on an identified date in 2017, identified the presence of a clean, beige large/extra large brief on the bed ready for use.
Interview with RPN # 601, following a review of the plan of care and Resident Profile Worksheet, verified that the plan did not give clear direction to staff who provided care related to the use of incontinent products. (Inspector #168) [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of a CIS submitted by the home and progress notes indicated that on an identified date in 2016, PSW's #604 and #605 provided morning care to resident #108. PSW #604 left the room briefly while PSW #605 remained with the resident. The resident was seated on the edge of the bed with PSW #605 in front of them, holding and supporting them, when the resident suddenly lost their balance and fell onto the floor. The resident sustained injuries and was transferred to hospital.
A review of the most current Rehab-Physiotherapy Assessment, dated two months prior to the incident, indicated that the resident was assessed and had one sided upper extremity weakness and poor trunk strength, and leans to the specified side.
A review of the written plan of care, in place at the time of the incident, did not identify the assessment findings of the physiotherapist or interventions to manage the weakness and poor trunk strength.
Interview with the DOC and the ADOC confirmed that the plan of care was not based on their assessed needs.

This non-compliance was issued as a result of CIS inspection #020120-16. (Inspector #214) [s. 6. (2)]

3. The licensee 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 complement each other.

Resident #102 sustained altered skin integrity in 2016, which required treatment. The Skin and Wound Assessment completed 19 days later, confirmed the affected area was still impaired. The RD documented "skin intact" the following month, Nutrition - Priority Screen.
The DOC confirmed the resident's skin was impaired at the time the Nutrition - Priority Screen was completed and that the assessments were not collaborative. [s. 6. (4) (a)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A review of a CIS submitted by the home and progress notes indicated that on a specified date in 2016, PSW #604 and #605 provided morning care to resident #108. PSW #604 left the room briefly while PSW #605 remained with the resident. The

resident was seated on the edge of the bed with PSW #605 in front of them, holding and supporting them, when the resident suddenly lost their balance and fell onto the floor. The resident sustained injuries and was transferred to hospital.
A review of the written plan of care, in place at the time of this incident, indicated that the resident required two staff extensive assistance for dressing, bed mobility and personal hygiene.
Interview with the DOC and ADOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan.

This non-compliance was issued as a result of CIS inspection #020120-16. (Inspector #214) [s. 6. (7)]

***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 the plan of care sets out clear directions to staff and others who provide direct care to the resident and that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident and that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other and that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and was implemented in accordance with applicable requirements under the Act.

O. Reg 79/10 section 49(1) requires every licensee of a long-term care home to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

A review of the home's policy, Scott Fall Risk Screen for Residential Long-Term Care, (RC-06-04-01 A2), review date of May 2016, indicated the following:
Scott Fall Risk Screen for Residential Long-Term Care to be completed when there is a serious fall with injury.

A review of a CIS submitted by the home and progress notes indicated that on a specified date in 2016, PSW #604 and #605 provided morning care to resident #108. PSW #604 left the room briefly while PSW #605 remained with the resident. The resident was seated on the edge of the bed with PSW #605 in front of them, holding and supporting them, when the resident suddenly lost their balance and fell onto the floor. The resident sustained injuries and was transferred to hospital.
A review of assessment's completed in Point Click Care (PCC) from mid 2016 to 2017, indicated that a Scott Fall Risk Screen for Residential Long-Term Care assessment had not been completed following the resident's fall with injury in 2016.
Interview with the DOC and ADOC confirmed that the home's policy had not been complied with.

This non-compliance was issued as a result of CIS inspection #020120-16. (Inspector #214) [s. 8. (1) (a),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 to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system was in compliance with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.***

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**WN #3: 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:**
**19. Safety risks. O. Reg. 79/10, s. 26 (3).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment with respect to the resident's safety risks.

On two identified dates in 2017, resident #103's left half bed rail was observed in the "assist" position.
On January 30, 2017, PSW #610 confirmed the resident used the left rail for transfers in and out of bed.
On January 30, 2017, the ADOC confirmed the bed rail was used as a PASD and that there was no PASD assessment completed nor was the use of the PASD identified in the written plan of care.
The plan of care was not based on an interdisciplinary assessment of the resident's safety needs. [s. 26. (3) 19.]

***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 the plan of care is based on an interdisciplinary assessment with respect to the resident's safety risks, to be implemented voluntarily.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that they had a dining and snack service that included, at a minimum, food and fluid being served at a temperature that was both safe and palatable to the residents.

On January 30, 2017, the resident #201 reported that the food served was not consistently warm enough.
On January 31, 2017, during lunch observation the temperature of the first and second choice for meals was taken.
The temperature of the foods dropped during the meal service, which was approximately 40 minutes in length.
The temperatures of food items were taken by the cook/dietary aid #613.
The mushroom strata, was initially taken at 172 Fahrenheit (F) and the turkey reuben sandwich 168 F.
Near the completion of serving the meal service the temperatures were taken again by staff #613 and the strata was found to be 120 F and the sandwich 110 F, both below the normal temperatures, for food recorded, as a reference on home area Temperature Sheet.
The Temperature Sheet, maintained by the home, identified normal food temperatures for hot food to be a minimum of 140 F.
Resident #201 was interviewed during the January 31, 2017, meal service and verified that the food was not warm enough.
On January 31, 2017, the Nutrition Manager indicated that the food was to be served at or above 140 F, to the residents.
The food in the home was served at a temperature that was not palatable to the residents. [s. 73. (1) 6.]

***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 the home has a dining and snack service that includes, at a minimum, food and fluid being served at a temperature that is both safe and palatable to the residents, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

**Specifically failed to comply with the following:**

**s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:**
**1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).**
**2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).**
**3. Behaviour management. 2007, c. 8, s. 76. (7).**
**4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).**
**5. Palliative care. 2007, c. 8, s. 76. (7).**
**6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that all staff who provided direct care to residents received, annual training in accordance with O Reg 79/10 section 221, specifically related to continence care and bowel management, skin and wound care, the use of application of physical restraints and PASDs and falls prevention and management, as a condition of continuing to have contact with residents.

A. A document provide by the home indicated that not all staff, who provided direct care to residents in 2016, received training in the area of continence care and bowel management.
The DOC verified that training was completed and offered in the home in 2016, related to continence care and bowel management; however, only 62 percent of staff participated in the required training.
Not all direct care staff received the required training, in continence care and bowel management, as a condition of continuing to have contact with residents in 2016. (Inspector #168)

B. Interview with the DOC confirmed that 38 percent of staff who provided direct care to residents, received as a condition of continuing to have contact with residents, annual retraining in the area of skin and wounds, in 2016, and that not all direct care staff received the annual retraining as required. (Inspector #130).

C. Interview with the DOC confirmed that 42 percent of staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in the use of physical restraints and PASDs, in 2016, and that not all direct care staff received the annual retraining as required. (Inspector #130).

D. Interview with the DOC confirmed that 62 percent of staff who provided direct care to residents received as a condition of continuing to have contact with residents, annual retraining in the area of falls prevention and management, in 2016, and that not all direct care staff received the annual retraining.
This non-compliance was issued as a result of CIS inspection #020120-16. (Inspector #214) [s. 76. (7)]

***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 staff who provide direct care to residents receive, annual training in accordance with O Reg 79/10 section 221, specifically related to continence care and bowel management, skin and wound, falls management and prevention and physical restraints and PASD's, as a condition of continuing to have contact with residents, to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A review of a CIS indicated that on a specified date in 2016, resident #107 was found on the floor in front of their bed. The resident and the bedroom floor were noted to be wet, with what appeared to be urine, at the time of the incident. The resident was transferred to hospital and was diagnosed with an injury.
A review of the resident's written plan of care indicated under the falls focus that staff were to do a visual check every 60 minutes for safety and under the toilet care focus, it was indicated that staff were to offer the resident one of two identified interventions to support bladder continence at an identified time.
A review of the Point of Care (POC) documentation identified that were no tasks recorded to document these interventions. Interview with the RAI Coordinator and the ADOC confirmed that staff had not documented the 60 minute safety checks nor the interventions, at the identified time, as the POC documentation had not been set up with the specified tasks for staff to document their actions.

This non-compliance was issued as a result of CIS inspection #0011641-16. (Inspector #214) [s. 30. (2)]

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

**Specifically failed to comply with the following:**

**s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).**

**Findings/Faits saillants :**

1. The Long-Term Care Home Service Accountability Agreement (LSAA) with the Local Health Integration Network (LHIN) under the Local Health System Integration Act, 2006, required the licensee to meet the practice requirements of the RAI-MDS (Resident Assessment Instrument - Minimum Data Set) system, which required each resident's care and service needs to be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team within 92 days of the assessment reference date (ARD) of the previous assessment, and Resident Assessment Protocols (RAPs) to be generated and reviewed and RAPs assessment summaries completed for triggered RAPs and non-triggered clinical conditions within 7 days maximum of the Assessment Reference Date (ARD).

The licensee did not comply with the conditions to which the licensee was subject in relation to the completion of the RAP assessment summary.

A. The MDS Assessment completed for resident #100, in January 2017, section P(4) indicated that bed rails were used daily. Coding in section G(6) indicated that bed rails were used daily for bed mobility or transfers.
The existing RAP for ADL (activity of daily living) – Functional Rehabilitation Potential indicated it was a modified Functional Rehabilitation Potential RAP; that the resident required limited assistance for bed mobility; however, there was no assessment summary related to the resident's need for a PASD for bed mobility.
On January 30, 2017, the ADOC confirmed the RAP assessment summary should have included the need for a PASD for bed mobility. (Inspector #130).

B. The MDS Assessment coding completed for resident #102, on November 2016, in section M(1)b and M(2)a, indicated the resident had altered skin integrity. The modified RAP for skin integrity did not identify that the resident had altered skin integrity nor were there objectives specified, despite the coding which indicated a worsening of skin integrity from the last Quarterly Review Assessment completed.
On January 30, 2017, the ADOC confirmed the RAP assessment summary should have included a summary related to the altered skin integrity and should have specified objectives. (Inspector #130). [s. 101. (4)]

**Issued on this 3rd day of February, 2017**

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| **Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs** |

**Original report signed by the inspector.**