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 # / Registre no	Type of Inspection / Genre d'inspection
Mar 7, 2017	2017_556168_0003	034457-16	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

LISA VINK (168), 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 Complaint inspection.

This inspection was conducted on the following date(s): January 30, 2017 and February 1, 2, 3 and 8, 2017.

This complaint inspection was conducted related to plan of care, transferring and positioning techniques and continence care and bowel management.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the former Administrator, the Regional Director, the Director of Care (DOC), registered nurses (RN), registered practical nurses, physiotherapists (PT), personal support workers (PSW), Nutrition Manager, the Resident Assessment Instrument (RAI) coordinator, family members and residents.

During the course of this inspection, the inspectors observed the provision of care and services, reviewed relevant records including policies and procedures, clinical health records, complaint logs and other documents provided by the home and family members.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Medication
Nutrition and Hydration
Personal Support Services
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 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. (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. (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).

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 failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. In February 2017, a source reported that resident #200 was not provided with a specific food, as they were not in the home to provide assistance to the resident.
On February 3, 2017, PSW #106 indicated that the direction in the resident's plan of care on providing the food were not clear.
Review of the plan of care included direction to provide the food along with other directions for the staff on offering other meals options and identification of the roles of

"attending assisting staff/POA/friend".
On February 3, 2017, the Nutrition Manager confirmed that the directions for the staff in the plan of care were not clear and the role of the staff and "attending assisting staff/POA/friend" was not clearly identified, which was confirmed by the DOC on February 8, 2017.

B. In February 2017, a source reported that resident #200 was not provided a specific food when it was to be served to the resident.
Review of the plan of care contained direction to provide the food (attending assisting staff/POA/friend will not request the food in the event that a condition was not met).
Review of the Meal Services Binder, used as a reference source in the servery by dietary staff during meals, contained information dated, prior to the plan of care which was reviewed, stated to provide the food if a specific condition was met and POA/caregiver present".
On February 8, 2017, the Nutrition Manager confirmed that the plan of care did not give clear direction to staff who provided care, as the two documents did not provide the same direction regarding who was an appropriate person to assist the resident.
The plan of care did not give clear direction to staff providing care. [s. 6. (1) (c)]

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

Resident #200's clinical record indicated that a quarterly Physiotherapy Assessment was completed in December 2016, by the PT, which identified the resident required a specific level of assistance.
Then on another date in December 2016, a quarterly transfer assessment was completed by RN #107 which indicated that the resident required a different level of assistance.
A review of the clinical record from the date of the first assessment until the second in December 2016, had not identified any changes in the resident's health status.
According to documentation the resident was transferred using both assessed methods of transfer.
The DOC confirmed that transfer assessments were completed by both the RN and the PT; however, the assessment completed by the RN would be the assessment that the home followed.
The DOC verified that both the RN and PT transfer assessments were included in the

clinical record and that the staff involved in the different aspects of care of the resident had not collaborated in the assessment of the resident so that their assessments were integrated, consistent and complimented each other related to the resident's transfer status. [s. 6. (4) (a)]

3. 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.

The plan of care for resident #200 identified under a specific focus statement an intervention, related to a specified action.
Progress notes of an identified date in September 2016, identified the resident was in a situation where staff action was completed to ensure safety. The note identified that the resident demonstrated an action and as a result staff did not carry out the identified intervention as per the plan of care.
Interview with RN #108 verified that they did not carry out the intervention as outlined in the plan of care when the resident demonstrated the action, on the identified date.
There was no mention in the notes that the action was carried out.
Interview with RN #109 verified that they were aware of the intervention on the identified date and directed RN #108 that they may need to carry out the intervention.
RN #109 verified that the plan of care directed staff to carry out the intervention in the specific situation.
Interview with the specific individual verified their request for the intervention and that it was not carried out on the identified date.
Interview with the DOC verified that the progress notes demonstrated that the resident was in the specific situation on the identified date and that the plan of care directed staff to carry of the intervention.
The care set out in the plan of care was not provided on the identified date to the resident. [s. 6. (7)]

4. The licensee failed to ensure that the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

Resident #200 had a physician's order for a medication, which directed staff to give the medication on an as needed basis when the resident demonstrated a situation.
The medication was discontinued by the physician in March 2016; however, the current written plan of care directed staff to administer the drug, as needed, in certain situations.
On February 3, 2016, the DOC confirmed the written plan of care was not revised with changes in the resident's care needs, when the drug was discontinued in March 2016. [s.

6. (10) (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 there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complement each other, that the care set out in the plan of care is provided to the resident as specified in the plan and to ensure that the plan of care is reviewed and revised at least every six months and at any other time when the resident's care needs change, to be implemented voluntarily.

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, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The LTCHA, 2007, section 21 identified that long-term care homes are to have a written

procedure that complies with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.

The licensee had a policy and procedure in place titled Complaints and Customer Service, RC-11-01-04, last updated April 2016, which was provided by the home as the current complaints process in place.
This procedure identified that all staff were to "complete a concern /complaint investigation form in detail and forward to the Administrator" and that the Administrator / department manager /designate shall "maintain a record of all complaints and actions taken in the complaints log".

A source provided two letters of complaint forwarded to the licensee of the home regarding the care provided to a resident.
A. An email, from July 2016, was sent to the Administrator. This email included a request for information, request for action and a concern related to a resident, as verified by the DOC. This email was responded to by the Administrator the following day, at which time a request was made to hold a meeting to review the issues, which was completed.
B. A letter of complaint was sent to the President of Extendicare Canada and copied to the Administrator of the home, regarding the care and services provided to the resident. Interview with the Administrator verified receipt of the letter. This letter was shared with the Administrator of the home and the DOC according to staff interviews. The Administrator and DOC reported that they held a meeting with the source as a result of the letter and in an attempt to resolve outstanding issues the following month.

A review of the complaints binder by the DOC did not include a completed or initiated concern /complaint investigation form (hard copy or electronic) for the two complaints, as identified by the DOC.
A review of the appropriate complaints logs did not include a record of the two complaint letters, as verified by the DOC.
Interview with the Administrator verified that they did not record the two complaints on the log, as they were ongoing and outstanding issues, which in their opinion the the home was attempting to resolve, and that the issues in the letters were previously included on the log when first identified and left as "outstanding".
A review of the log included a column with the heading "Is this a repeated complaint? (Complaint on the same issue from the same complainant or on behalf of the same patient/resident)" which directed staff to identify a number "1" if it was a "yes" and to enter the original complaint number if this was a repeated complaint.

Interview with the Regional Director verified the expectation that the log should have been amended when the two letters of complaint were received; however, supported the comments of the Administrator, that the issues were known to the home, were outstanding and in their opinion the home was attempting to resolve.
The home did not comply with their policy and procedure regarding Complaints and Customer Service as required. [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 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, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: 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.

In December 2016, it was reported that resident #200 did not have a care need met on a regular basis by staff.
On February 2 and 3, 2017, PSW #100, indicated that they provided the care to the resident under specific situations and when not able to meet this need it would be completed by another individual.
Review of the current written plan of care indicated that staff were to provide the care daily and if unable notify the appropriate individual who would carry out the task.
On February 3, 2017, PSW #100 identified that there was no specific task in Point of Care (POC) to document the specific care need nor the resident’s response, which was confirmed during a review of the POC documentation system.
A review of the POC documentation included the specific task with the general tasks of "Day Care" for the resident.
It was identified that the residents level of participation, assistance and/or acceptance of the care need was frequently different than that of the other tasks identified under "Day Care". When staff documented in POC the completion of care and the acceptance or refusal they were not able to record different information for each of the separate tasks under the "Day Care" interventions.
On February 8, 2017, the RAI Coordinator confirmed that there was no specific task included in POC for the staff to document the specific intervention nor the resident’s response.
The licensee did not ensure that any actions taken with respect to a resident under a program, including interventions and the resident’s responses to interventions were documented. [s. 30. (2)]

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 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's Administrator, worked regularly in that position, on site at the home, for the following amount of time per week, in a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week.

Extendicare Halton Hills is a 130 bed long-term care home.
The former Administrator left their position at the home on January 19, 2017.
The home currently has an acting Administrator, who also works as an Administrator, at a 140 bed long-term care home in a neighboring community.
Interview with the acting Administrator verified that since their appointment to Extendicare Halton Hills, they work onsite approximately one day a week at the home, and is in touch with the DOC, on an as needed and daily basis, by phone to provide any support or direction needed.
The acting Administration identified that in addition to their onsite presence approximately once a week, the corporate Regional Director is working onsite approximately two to three days a week to provide support and direction and is also available by phone.
Interview with acting Administrator identified that for the week of January 30, 2017 until February 3, 2017, they were onsite for approximately half of a day. Interview with the Regional Director identified that during the same time period they were onsite two days.
It was identified by the acting Administrator that interviews had been conducted to fill the vacant Administrator position; however, at this time no decisions have been announced regarding the successful applicant or a start date.
The home's Administrator did not worked regularly, on site at the home, at least 35 hours per week, since January 19, 2017. [s. 212. (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 the home's Administrator, works regularly in that position, on site at the home, for the following amount of time per week, in a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week, to be implemented voluntarily.

Issued on this 8th day of March, 2017

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

Original report signed by the inspector.