Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 13, 2019	2019_723606_0019	028597-18, 030341-18, 032096-18	Critical Incident System

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 Brampton
7891 McLaughlin Road BRAMPTON ON L6Y 5H8

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

JANET GROUX (606)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 22, 23, 27, 28, and 29, 2019. Long Term Care Homes (LTCH) Inspector Lucia Kwok #752 took part in this inspection.

The following Critical Incident System (CIS) intakes were inspected:
Log # 030341-18, regarding a resident who sustained a serious of unknown cause;
Log #0233-19-18 and Log #032096-18 regarding a resident fall resulting in serious injuries.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Corporate Clinical Consultant, Maintenance staff, Substitute Decision Makers (SDM) and Residents.

During the course of the inspection, the Inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records such as progress notes, assessments, physician orders, written care plans, reviewed relevant home's investigation records, home's meeting minutes, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. (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 has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A Critical Incident System (CIS) reported resident #002 fell and was diagnosed with a serious injury.

Resident #002's plan of care identified the resident to be at an identified risk of falling and one of the interventions to manage the risk was for staff to ensure that commonly used items such as their call bell was within easy reach.

Resident #002 stated that after they fell, they no longer tried to get up on their own and would use their call bell to call staff for assistance. However, resident #002 revealed that staff did not always put the call bell where they could reach it.

The Long Term Care Homes (LTCH) Inspectors observed on identified dates and times resident #002's call bell was out of reach from the resident. On an identified date and time, the resident confirmed that they were not able to reach their call bell and demonstrated this to the Inspectors. Registered Practical Nurse (RPN) #102 was present to witness this and acknowledged that the call bell was out of reach of resident #002.

The licensee has failed to ensure that resident #002's call bell was within easy reach as stated in their plan of care. [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 care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was on at all times.

Resident #004 was assessed to be at an identified risk level for falls. Their plan of care stated that commonly used items including the call bell were to be within reach to manage their risk of falling.

The home's call bell system consisted of a pull cord with a call bell button at one end. The pull cord is plugged into a call bell pull cord station that can be easily dislodged when the call bell cord is tugged or pulled. A call bell is activated when the call bell button is pressed. When the call bell button is pressed, the call bell pull cord station's "cancel" button lights up to indicate that the call bell has been activated. The "cancel" button can only be deactivated at the source. A message to the staff is sent via pager, or nurse call bell panel at the nursing station to let them know that a resident required assistance at the location the call bell was activated from.

Inspectors #606 and #752 completed observations on an identified date and time. During the observations, resident #004 stated that their call bell had not been working and that the issue had been ongoing. The resident pushed the call bell button to show that the call

bell was not working. Both Inspectors #606 and #752 pushed the call bell button and observed that the pull cord station "cancel" button light did not turn on.

Resident #004 told the Inspectors that when their call bell was not working, they would alert the staff by performing an identified action and demonstrated the action. Personal Support Worker (PSW) #111 stated that they were aware that resident #004's call bell did not work from time to time. PSW #111 told the Inspectors that they had not received any call bell notification from resident #004 since earlier during the shift.

Registered Practical Nurse (RPN) # 110 acknowledged that the call bell occasionally did not work. RPN #110 stated resident #004's call bell was functioning at an identified time earlier during the shift.

A call bell report is a document that provides a record of the location, time, length of time, and date each time a call bell was activated and deactivated. In a resident's room there are two call bells located in identified areas of the room.

Review of resident #004's room call bell report on identified dates and time showed the call bell was activated on identified dates and times. The call bell report did not show the call bell was activated at an identified time and date as stated by RPN #110. The resident told the Inspectors that their call bell was not working earlier during the shift.

Maintenance care records indicated that resident #004's call bell was not working on an identified date and the call bell had been repaired by maintenance staff #112. Maintenance staff #112 acknowledged that no alternative call bell equipment had been trialed for resident #004. They stated when resident #004's call bell was not working, the corrective action was for staff to call maintenance.

The licensee has failed to ensure the communication system was on at all times for resident #004. [s. 17. (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 the home is equipped with a resident-staff communication and response system that is on at all times, to be implemented voluntarily.

Issued on this 18th day of September, 2019

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

Original report signed by the inspector.