Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 7, 2020	2020_826606_0002	022229-19	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 Halton Hills
9 Lindsay Court Georgetown ON L7G 6G9

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): January 9, 10, 13, and 14, 2020.

The following Critical Incidents (CI) were inspected:
Log #022229-19 regarding a resident fall resulting in a fractured hip.

PLEASE NOTE: A Written Notification and Voluntary Plan of Correction related to LTCHA, 2007, c.8, s. 6(7)), identified in a concurrent inspection # 2020_826606_0001 (Log #022864-19 and #023879-19) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the home's Falls Prevention Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

The inspector(s) conducted observations of resident care, residents and staff interactions, completed interviews and reviewed residents' clinical records including progress notes, assessments, physician orders, plans of care, 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
Nutrition and Hydration

During the course of this inspection, Non-Compliances were issued.
- **1 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	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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

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. A Critical Incident (CI) reported resident #007 fell and sustained an injury which resulted in a significant change in their condition.

Resident #007's Point Click Care (PCC) post fall assessment on an identified date stated the resident was at a risk level for falls. It was identified that their falls prevention device was not in place.

Resident #007's plan of care directed the staff to ensure that the resident was assisted with an identified activities of daily living (ADL) at specified times. An identified fall prevention device was to be applied at identified times. RN #105 and PSW #107 said resident #007's fall prevention device was not in place as required in resident #001's plan of care.

B. The Long Term Care Homes (LTCH) Inspector observed on an identified date and time, resident #007 with an identified part of their falls prevention device missing from their chair. Registered Practical Nurse (RPN) #121 confirmed this and stated that the identified part of the device should have been attached to the chair for the falls prevention device to function. PSW #122 acknowledged that they did not check to make sure resident #007's falls prevention device was in place.

C. Resident #005's PCC falls assessment on an identified date stated the resident was at

a risk level for falls. Resident #005's plan of care directed staff to apply the fall prevention device at specified times and to ensure the falls prevention device was working and turned on.

The LTCH Inspector observed on an identified date and time, a part of resident #005's fall prevention device was not attached to the resident. PSW #103 acknowledged that the falls prevention device should have been attached to the resident's clothing for it to function.

D. A complaint submitted to the Ministry of Long Term Care (MLTC) reported an allegation in which resident #001 was not provided assistance for an specified ADL after the resident had a change in their condition.

Resident #001's Substitute Decision Maker (SDM) alleged that the resident was not provided assistance with an identified ADL.

Resident #001's progress notes on an identified date stated the resident had a change in their condition after they fell and was transferred to the hospital. The resident returned from the hospital and required assistance for a specified ADL. PSW #103, Registered Nurses (RN) #102 and #105 acknowledged this.

PSW #105 stated that they were assigned to provide care to resident #001 on an identified date but they were not aware that the resident required assistance with an identified ADL. They stated that they were given directions to provide care to another resident.

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #001, #005 and #007 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that when the care set out in the plan of care had not been effective, different approaches were considered when the plan of care was being revised.

A CI reported resident #007 fell and sustained a serious injury.

Resident #007's progress notes on an identified date stated the resident fell after they had attempted to provide an identified ADL without staff assistance. The progress notes stated that prior to the fall on an identified date, resident #007 had fallen a number of

times from attempting to provide an identified ADL on their own. It was assessed that a falls prevention device to manage the resident's risk of falling was not in place as required, contributing to their fall.

PSW #107 and RN #105 stated that resident #007 's identified behaviour would cause the falls prevention device to be ineffective.

Resident #007's plan of care did not show evidence that other strategies were identified after it was determined that an identified falls prevention device was ineffective.

The licensee has failed to ensure that the plan of care was revised when the identified falls prevention device was not effective for falls prevention for resident #007.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 is provided to the resident as specified in the plan and to ensure that when the care set out in the plan of care has not been effective, different approaches are considered when the plan of care is being revised, to be implemented voluntarily.

Issued on this 21st day of February, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	JANET GROUX (606)
Inspection No. / No de l’inspection :	2020_826606_0002
Log No. / No de registre :	022229-19
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 7, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Halton Hills 9 Lindsay Court, Georgetown, ON, L7G-6G9
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Emily Bosma

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 Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 001

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. (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).

Order / Ordre :

The licensee must be compliant with s.6(7) of the LTCHA.

Specifically, the licensee shall ensure that:

a) a chair and bed falls prevention devices are in place for residents #005, #007 and any other resident as specified in the resident's plan of care; and
b) residents #005 and #007's falls prevention devices are checked each shift to ensure it is in place and in working order. This check should be documented in the residents plan of care.

Grounds / Motifs :

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. A Critical Incident (CI) reported resident #007 fell and sustained an injury which resulted in a significant change in their condition.

Resident #007's Point Click Care (PCC) post fall assessment on an identified date stated the resident was at a risk level for falls. It was identified that their falls prevention device was not in place.

Resident #007's plan of care directed the staff to ensure that the resident was assisted with an identified activities of daily living (ADL) at specified times. An identified fall prevention device was to be applied at identified times. RN #105 and PSW #107 said resident #007's fall prevention device was not in place as required in resident #001's plan of care.

B. The Long Term Care Homes (LTCH) Inspector observed on an identified date and time, resident #007 with an identified part of their falls prevention device missing from their chair. Registered Practical Nurse (RPN) #121 confirmed this and stated that the identified part of the device should have been attached to the chair for the falls prevention device to function. PSW #122 acknowledged that they did not check to make sure resident #007's falls prevention device was in place.

C. Resident #005's PCC falls assessment on an identified date stated the resident was at a risk level for falls. Resident #005's plan of care directed staff to apply the fall prevention device at specified times and to ensure the falls prevention device was working and turned on.

The LTCH Inspector observed on an identified date and time, a part of resident #005's fall prevention device was not attached to the resident. PSW #103 acknowledged that the falls prevention device should have been attached to the resident's clothing for it to function.

The licensee has failed to ensure that the care set out in the plan of care was provided to residents #005 and #007 as specified in the plan.

The severity of this issue was a level 3 as there was actual harm. The scope was level 2 as it involved two out of three residents. The home had a level 3 history of a previous non compliance (NC) to the same subsection with a Written Notification (WN) during a Follow Up Inspection #2019_798738_0021 issued on October 30, 2019, and a Voluntary Plan of Correction (VPC) during a Complaint Inspection #2017_556168_0003 issued on March 7, 2017.

(606)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 09, 2020

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 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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 7th day of February, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Janet Groux

Service Area Office /
Bureau régional de services : Central West Service Area Office