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

Health System Accountability and Performance Division
Performance Improvement and Compliance 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
Nov 26, 2015	2015_396103_0054	O-002659-15	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 COBOURG
130 NEW DENSMORE ROAD COBOURG ON K9A 5W2

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

DARLENE MURPHY (103), DENISE BROWN (626), JESSICA PATTISON (197), JULIET MANDERSON-GRAY (607)

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): October 27-30, November 2-6, 2015

The following intakes were included in this inspection: O-002072-15, O-002074-15, O-002424-15, O-002432-15, O-002433-15, O-002489-15, O-002558-15, O-002730-15, O-002755-15, O-002805-15 and O-031306-15.

During the course of the inspection, the inspector(s) spoke with Residents, Representative of Resident Council, Family Council President, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Registered Dietitian (RD), Food Service Manager (FSM), Housekeeping aide, Environmental Manager, Physiotherapist (PT), Activation Manager, RAI Coordinator, Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspectors conducted a full walking tour of the home, made dining room and resident care observations, observed medication administration and practices, reviewed resident health care records, observed and reviewed infection control practices, reviewed resident and family council minutes, applicable home policies, the home's documented complaint record, the home's staffing schedules for the nursing department and the home's staffing plan.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **11 WN(s)**
- **3 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. (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 plan of care set out clear directions to staff and others who provide direct care to the resident.

On October 30, 2015, Inspector #607 observed resident #038 to be not wearing dentures. Review of the resident's plan of care, indicated the resident had full top and bottom dentures, and he/she is to be encouraged to wear the upper dentures during the day and the lower denture for short periods of time.

Interview with PSW #108 revealed the resident's dentures do not fit. Interviews with PSW #101 and RPN #104 revealed the resident has dentures, but refuses to wear them. Resident #038 was not interviewable.

Interview with the DOC confirmed that when there is change in resident care, the expectation is that the care plan be updated. [s. 6. (1) (c)]

2. Resident #013's most recent MDS assessment indicated that the resident is occasionally incontinent of bowel and frequently incontinent for bladder.

During an interview with PSW #114, she indicated that resident #013 is occasionally incontinent of bowel.

Resident #013's current care plan indicated the resident was incontinent of urine, but does not give any directions related to bowel routines or bowel continence. [s. 6. (1) (c)]

3. Resident #035's most recent MDS assessment indicated that the resident has impaired vision.

During an interview with PSWs #108 and #113, they indicated it's best for staff to approach the resident from the front and not the side. This inspector asked the staff if this was written anywhere to instruct staff.

Review of Resident #035's current care plan indicated no information or directions to staff related to the resident's vision. [s. 6. (1) (c)]

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

On a specified date, resident #027 fell and sustained an injury. Resident #027's resident health care record was reviewed related to fall prevention. The resident's current care plan in effect at the time of this inspection indicated the resident was assessed as a high risk for falls and the following interventions were in place to reduce the risk of falls:
-coordinate with appropriate staff to ensure a safe environment eg: floor surfaces even,
-fall mat at side of bed,
-glare-free lighting,
-bed in low position, and
-personal items within reach.

The inspector observed resident #027 did have a high low bed, but there was no evidence of a fall mat in the room. The resident was interviewed and stated to his/her recollection, a fall mat had never been used.

PSW staff were interviewed and stated they could not recall a fall mat being used at any time with this resident. The DOC was also interviewed and stated to her knowledge this resident has never had a fall mat. [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 residents #038, #013, #035 care plan are updated to accurately reflect their specific care needs and to ensure resident #027's fall prevention measures are accurately outlined in the care plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure a resident at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

A review of resident #032's progress notes revealed that the resident was transferred to the hospital on five separate identified dates and there were no skin assessments completed upon return to the home.

Interview with RPN #136 confirmed that no skin assessments were completed for the resident for the identified dates. [s. 50. (2) (a) (ii)]

2. Resident #039's health care record was reviewed. The care plan in place at the time of this inspection indicated the resident was a high risk for skin impairment.

Resident #039 was admitted to hospital on an identified date and returned to the home five days later. On an identified date three days after the resident returned to the home, the progress notes indicated the resident had bruising that may have corresponded with a treatment while in hospital. Two additional days later, the resident was observed to have an identified new area of pressure. The resident did not have a documented skin assessment completed following the hospitalization until twelve days after the resident returned to the home from hospital. [s. 50. (2) (a) (ii)]

3. The following finding relates to Log O-002730-15:

Resident #049's health care record was reviewed and indicated the resident was a moderate risk for skin impairment. Resident #049 was admitted to hospital on an identified date and returned to the home four days later. Two days after returning to the home, the resident was observed to have an identified stage 1 pressure ulcer and pressure relieving measures were implemented.

The home failed to have a documented skin assessment completed post hospitalization until two days after the resident returned to the home from hospital. [s. 50. (2) (a) (ii)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review of resident #038 skin assessment indicated that the resident was identified as having three separate pressure ulcers.

Documented weekly wound assessments were not completed for identified periods of time.

Interview with an RN #109 and the DOC confirmed that weekly wound assessments had not been conducted for the resident during the identified periods. [s. 50. (2) (b) (iv)]

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 a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital and residents exhibiting altered skin integrity skin is reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 74(2) in that the Registered Dietitian for the home was not on-site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

In an interview with the current Registered Dietitian (RD) for the home, she indicated that she started working in the home in August 2015. She stated that she is funded for 8 hours per week and that her regular day in the home is Tuesday. This would mean that most months when there are only four Tuesdays, the RD would be working 32 hours per month.

The maximum capacity for the home is 69 residents, meaning that the requirement is 34.5 hours of RD time per month. (0.5 hours x 69 residents)

In August 2015, the billed RD hours provided by the home were 32. The census report provided by the home indicated that there were 68-69 residents in the home during this month, indicating a requirement of 34 to 34.5 hours. [s. 74. (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 to ensure the Registered Dietitian for the home is on-site for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

On October 30, 2015, resident #038's wheelchair was observed with food debris on the seat and on November 2, 2015 was observed to have additional food debris noted on the armrest of the wheelchair.

On October 30, 2015, resident #032's wheelchair was observed to have white spills on the inner left side of the wheelchair and on November 2, 2015, the resident's wheelchair was observed to have spills noted on both sides of the wheelchair seat.

Interviews with RN #100 and the DOC confirmed that the above wheelchairs were unclean and it is the night staff's responsibility to ensure wheelchairs are cleaned on a regular basis.

A review of the cleaning book revealed that the above identified resident's wheelchairs were not documented as having been cleaned during the months of September or October, 2015. [s. 37. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

Interviews with resident #025 and a family member on November 4, 2015 revealed the resident is left in his/her housecoat to attend church services which occur on his/her scheduled bath day. The resident expressed that he/she does not like to attend these services in a housecoat. Additionally, the resident indicated following a bath he/she is returned to bed with wet hair and stated he/she does not like this.

Interview with PSW #139 confirmed that the resident's hair is often dried with a towel after baths. Following a discussion with the DOC, the home adjusted the resident's bath schedule so it no longer corresponds with the same day as the church services. [s. 40.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 40 in that Resident #050 was not dressed in accordance with his/her preferences when brought to the dining room.

During breakfast observation on November 5, 2015 on an identified unit, Resident #050 was observed to come to the dining room in a housecoat, escorted by PSW #114. The resident expressed being unhappy with being in the dining room in a housecoat.

On November 6, 2015, Resident #050 and a family member were interviewed whereby it was confirmed the resident would not like to attend meals in a housecoat. The current care plan for Resident #050 does not indicate this resident's preference. [s. 40.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 69 in that significant weight changes for resident #009 were not assessed using an interdisciplinary approach, and that actions were not taken and outcomes not evaluated.

Resident #009 was assessed as moderate nutritional priority and was provided with a nutritional supplement. The resident was noted to have weight loss during three consecutive months.

The first month's weight loss was assessed by the RD and the nutritional supplement was increased from once daily to three times daily. A review of resident #009's clinical record showed no assessment of the next two months of weight loss.

The RD was interviewed on October 29, 2015 and indicated that she relies on referrals for assessing weight changes as she is only in the home one day per week. She further stated that when she came to the home there was a backlog of referrals and MDS assessments to be done. She stated she prioritized the MDS and then got to the referrals later. This inspector inquired about resident #009 and she indicated she was aware of this resident and would be completing an assessment soon. She stated that typically her practice would be to get to significant weight changes within 2 weeks (2 working days). [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #7: 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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 73(1)10 in that proper techniques were not used to feed residents who required assistance during a breakfast meal service.

On November 5, 2015, the breakfast meal was observed on a specified unit. Three PSWs were in the dining room. Two were providing feeding assistance (#114 and #120), while the other was serving residents (#105).

During the meal service, the following was observed:
-PSW #114 was observed three times to provide feeding assistance to Resident #011 while standing.
-PSW #114 was observed four times to provide feeding assistance to Resident #019 while standing.
-PSW #114 was observed once to provide feeding assistance to Resident #026 while standing.
-PSW #105 was observed once to provide feeding assistance to Resident #039 while standing.

Standing above a resident while feeding can cause hyperextension of the neck which opens the airway and increases the risk of aspiration. [s. 73. (1) 10.]

2. The licensee has failed to comply with O. Reg. 79/10, s. 73(2)(a) in that staff members

assisted more than two residents at the same time, who needed total assistance with eating or drinking during a breakfast meal service.

The following findings relate to Log O-002489-15:

On November 4, 2015, PSWs #114 and #120 were interviewed on an identified unit related to staffing levels in the home. Both indicated that residents were not getting proper feeding assistance and believed an additional staff member was needed.

On November 5, 2015, the breakfast meal on an identified unit was observed from 0830 to 0925 hours. Three PSWs were observed in the dining room. PSWs #114 and #120 were providing feeding assistance, while PSW #105 was serving the meal.

PSW #114 was observed to sit between Residents #008 and #026, but throughout the meal got up frequently to help the other two residents at the table, Residents #019 and #020.

The current care plans for these residents indicate the following:
-Resident #008 requires total feeding assistance,
-Resident #026 requires extensive to total feeding assistance,
-Resident #020 requires extensive feeding assistance,
-Resident #019 requires supervision with set-up help.

The inspector interviewed PSW #146 who stated the care plan for resident #019 was not accurate and the resident requires extensive feeding assistance by staff. Observations made by the inspector also indicated that extensive feeding assistance for this resident was required.

On November 6, 2015, the Food Service Manager (FSM) was interviewed. This inspector discussed observations at the breakfast meal on the identified unit and the FSM indicated that PSWs #105 and #114 came to her recently to discuss their concerns regarding staffing in the dining room. The FSM indicated that the home will be implementing changes to this dining room as more residents are requiring feeding assistance. [s. 73. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure all hazardous substances at the home are kept inaccessible to residents at all times.

On October 27, 2015 at 10:45 a.m., Inspector #607 observed a cupboard in the activity room on an identified unit with six cans marked porcelain ceramic sealer and super gloss ceramic sealer. The cans indicated flammable and poison on the containers. Interview with the PSW #101 confirmed that the cupboards should be locked and went to get a staff member to lock the cupboard. Interview with the DOC confirmed that the cupboards should be locked when unsupervised. [s. 91.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint.

During stage one of the RQI interviews, residents #009 and #027 stated identified items had gone missing within the past year.

Resident #009's progress notes were reviewed and on an identified date there was documentation to support the resident reported an identified item went missing. Resident #027's progress notes were reviewed and there was documentation on an identified date to support the resident reported an identified item went missing.

Interview with the DOC confirmed that the home utilizes the documented record for all verbal and written complaints and that staff are to complete a complaint form whenever resident's items go missing and cannot be located within a twenty four hour period of time.

A review of the home's complaint log was completed and there was no documentation related to the missing items for residents #009 and #027. [s. 101. (2)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the home's written policy related to the disposal of discontinued medications was followed.

On October 27, 2015, Inspector #607 observed two containers of identified creams in resident #003's bathroom.

A review of home's pharmacy policy titled "Discontinued Medications", policy # 4-10 dated 01/14 stated:
-Remove discontinued drug from all areas
-Place drug in area for destruction.

Interview with RN #100 confirmed that the above identified creams were discontinued and should not have been left in the resident's room.

Interview with the DOC confirmed the expectation is as soon as medicated creams are discontinued, they should be discarded. [s. 114. (2)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:

7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home

On November 02, 2015, the inspector observed a packing slip dated October 29, 2015, with medication not signed for as being received for the following residents, #041, #025, #042, #37, #043 and #003. Interview with RN #100 revealed that the night nurses are responsible for signing medication packing slips upon receipt of medications, and that the packing slips were not signed. Interview with the DOC confirmed that the evening nurse would ensure that medications are checked, received and packing slips should be signed. [s. 133.]

Issued on this 26th day of November, 2015

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

Original report signed by the inspector.