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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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 3, 2018	2017_715554_0028	014843-17	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

KELLY BURNS (554), BAIYE OROCK (624), CRISTINA MONTOYA (461)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 12, 13, 18, 19, 20 and 22, 2017

Resident Quality Inspection (RQI) #104843-17. Intakes #022865-17 and #023482-17 were inspected concurrently with the RQI.

Summary of Intakes:
1) #022865-17 - Critical Incident Report (CIR) - alleged staff to resident neglect;
2) #023482-17 - Critical Incident Report (CIR) - alleged resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Office Manager, Programs Manager, Registered Dietitian, Environmental Services Manager, RAI-Coordinator, Registered Nurse(s), Registered Practical Nurse(s), Personal Support Worker(s), Housekeeping Aid(s), President of the Family Council, President of the Resident Council, Family and residents.

During the course of the inspection, the inspectors toured the long-term care home, observed staff to resident and resident to resident interactions, observed meal and snack service; reviewed clinical health records, specific licensee investigations, Resident Council Meeting Minutes, and reviewed licensee policies, specifically Continence Management Program, Zero Tolerance of Resident Abuse and Neglect, Falls Prevention and Management Program, Responsive Behaviours, and the Weight Change Program.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

- **5 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. (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 written plan of care set out the planned care, for resident #008 related to Falls Prevention.

Resident #008 was admitted to the long-term care home on on an identified date. Upon admission, the Falls Risk Assessment, for resident #008, was completed and attributed a identified score with direction (for staff) to "follow universal precautions to prevent falls."

Resident #008 sustained two falls on identified dates, one of which resulted in injury. After both falls, post falls assessments were completed and the resident's risk level was reviewed; resident #008 was classified as being at risk for falls. A review of the resident's admission as well as current written plan of care indicated that there was no focus, goals or interventions specifically related to falls prevention.

In separate interviews conducted with Registered Practical Nurse (RPN) #103 and the Director of Care, both indicated that the licensee's expectation is that the written plan of care should contain a focus, goals and interventions to prevent falls for resident #008. After reviewing both the electronic and hard copy care plans, both indicated that the care plan for resident #008 did not set out the planned care for the resident, specifically related to Falls Prevention.

The licensee failed to ensure that the written plan of care set out the planned care, for

resident #008, related to Falls Prevention. [s. 6. (1) (a)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to resident #021, as specified in the plan.

Related to Intake #022865-17:

The Director of Care submitted a Critical Incident Report (CIR), on an identified date, for an alleged incident of neglect. The staff to resident neglect incident occurred the previous day, and involved resident #021.

The Director of Care indicated, to Inspector #554, that resident #021 was assisted by identified staff to bed, at an identified hour on an identified date. Resident #021 was not provided care, and was not provided intake from the time he/she was settled to bed to an identified hour.

Resident #021 has a history which includes cognitive impairment. Resident #021 is dependent on staff for activities of daily living (ADL).

The clinical health record, for resident #021, was reviewed by Inspector #554.

Written Care Plan (identified date):

Resident #021 required extensive assistance, of staff, for activities of daily living, specifically, eating, dressing, personal hygiene, toileting, transfers and bed mobility.

Progress notes indicated the following for an identified date:
- Personal Support Workers assisted resident to bed at an identified hour. Resident went to sleep and remains in bed.
- Resident slept through meals during an identified shift.
- Resident #021 was received in bed at an identified hour, resident was asleep. Approximately two and a half hours later, Registered Practical Nurse (RPN) #112 observed resident to be stirring, and directed Personal Support Workers (PSW) to get resident up. Two and a half hours later, a PSW came to Registered Practical Nurse #112 stating they had just got resident up, and that resident was soiled, and was still in an identified continence product from an identified shift. PSW's indicated the bed, of resident #021, was soiled. The progress note indicated that resident had not been provided intake.

Personal Support Worker (PSW) #107, who worked on an identified shift, indicated, to Inspector #554, that resident #021 did not receive care, or intake on the identified shift.

Registered Practical Nurse (RPN) #111 indicated, to Inspector #554, that he/she had worked on the identified shift, and was aware that resident slept through meals. RPN #111 indicated that he/she had directed PSW's to provide resident care, and assumed care had been completed as per his/her direction. RPN #111 indicated that each time he/she passed resident #021's room, resident was in bed asleep. RPN #111 indicated he/she was informed via shift report (and later from the Director of Care) the next day that care for resident #021 had not been provided on the identified date.

Registered Practical Nurse #109, who was the resident home area supervisor, on the identified date, indicated, to Inspector #554, that PSW's had been directed by his/herself and RPN #111 to provide care to resident #021. RPN #109 indicated that each time he/she passed resident #021's room, resident was in bed asleep. RPN #109 indicated he/she had not followed up with PSWs as to if care, and intake had been provided to resident #021 that day.

The Director of Care indicated, to Inspector #554, that the licensee's investigated the alleged neglect incident, and concluded that resident #021 had not been provided care as set out in the plan of care, on the identified date.

Personal Support Workers #113, #114, Registered Practical Nurse #112, and Registered Nurse #116 who had been involved or had awareness of the care issues related to resident #021, were not available for interviews during this inspection.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #021, as specified in the plan on an identified date, and during specific hours.

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 there is a process in place and monitored, ensuring that there is a written plan of care for each resident that sets out, the planned care for the resident, specifically related to Falls Prevention; and that the care set out in the plan of care is provided as specified in the plan, 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Inspector #461 reviewed the licensee's policy 'Weight Change Program', which indicated the following:

All residents shall be weighed on admission and at least once a month. Individual weights will be analyzed for significant change based on the one, three and six month standards and actions taken and outcomes evaluated.

The licensee's policy, 'Weight Change Program' directs the following:

The care staff to weigh residents on admission, monthly or more frequently as required and record the weights either on paper or electronically. For monthly monitoring, every resident is to be weighed on the first bath day within the first seven (7) days of each month, minimally.

The registered staff to compare the monthly weight to the previous month's weight, and any weight with a 2.5 kilogram (Kg) difference from the previous month requires a re-weigh. Registered staff is to direct care staff to re-weigh resident.

The registered staff to ensure current weight of an individual resident, including re-weigh if applicable, is recorded by the tenth of each month either on paper or electronically.

Resident #005 was identified as having identified weight loss on an identified date.

Inspector #461 reviewed resident's clinical health records identifying that resident's weight recorded in the electronic record on an specific date, was an identified weight in kg. The identified weight in comparison to the previous month, presented a weight difference of 5.7 Kg. Resident's weight the previous month (two months from specific date) presented a weight difference of 11.2 Kg between the identified months. There was no indication that a re-weigh was completed during the identified months, when the weights recorded showed a difference of 2.5 Kg according to the licensee's policy. Furthermore, there was no assessment completed by the interdisciplinary team related to the weight changes.

During separate interviews with Registered Practical Nurse (RPN) #103 and Registered Dietitian (RD), both indicated, to Inspector #461, that Personal Support Workers (PSWs) were expected to enter the residents' weights in the electronic clinical health record by the seventh of each month. The registered staff was expected to review the weights entered and request the PSWs to re-weigh any resident with a weight difference of 2.5 Kg from the previous month. The RPN and RD further indicated that resident #005 was not re-weighed during the identified dates.

The Director of Care (DOC) indicated, to Inspector #461, that the licensee's expectation is that re-weighs are to be completed by the tenth of each month. The DOC acknowledged that the staff did not follow the licensee's policy related to completing re-weighs of resident #005 when there was a 2.5 Kg difference from the previous month in the identified time period.

The licensee failed to ensure that its policy for 'Weight Change Program', was complied with, specifically related to the re-weighing process, for residents. (461) [s. 8. (1) (b)]

2. The licensee failed to comply with its 'Falls Prevention and Management Program' related to initiating the flagging system for a high risk resident.

Under O. Reg. 79/10, s. 49 (1) - 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 was completed of the licensee policy entitled 'Falls Prevention and Management Program'. The licensee policy directed the following:

- Establish a flagging system to clearly identify to all staff the residents that are at high risk for falls.
- Initiate flagging system for all high risk residents for falls.

Resident #008 was admitted to the long-term care home on an identified date. Upon admission, the Falls Risk Assessment, for resident #008, was completed and attributed a an identified score with directions (for staff) to follow 'universal precautions to prevent falls'.

Resident #008 sustained two falls during identified dates, one of which resulted in injury. After both falls, post falls assessments were completed and the resident's risk level was reviewed and the resident was classified as being at risk for falls. A review of the resident’s clinical health care records did not reveal that a flagging system was initiated for resident #008 who had been identified as being at risk of falling.

In separate interviews by Inspector #624 with Personal Support Worker (PSW) #117, Registered Practical Nurse (RPN) #103 and Registered Nurse (RN) #118, they all indicated that the licensee has established the 'falling leaf' program as their flagging system, where residents identified as being at risk of falls get a symbol posted on their door frames to alert staff of the falls risk status of the resident. RPN #103 and RN #118 also indicated that it was the responsibility of the registered staff to initiate the flagging system when a resident in assessed as being at risk of falls.

Several observations of resident #008’s room was completed, by Inspector #624, on

identified dates and there was no symbol posted on either the resident's door or any part of the resident's room.

In an interview with the Director of Care (DOC), he/she confirmed the licensee expectation regarding the flagging system as reported by PSW #117, RPN #103 and RN #118 above. The DOC further indicated that the identified flagging system should have been initiated when resident #008 was deemed to be at risk of falling following the two fall incidents.

The licensee failed to comply with its Falls Prevention policy by not initiating the flagging system for a resident deemed at risk for falls. (624) [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 there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specifically as it relates to Falls Prevention and Management; and Nutrition and Hydration, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Under O. Reg. 79/10, s. 5 – for the purposes of the Act, and this Regulation, 'neglect' means the failure to provide a resident with the treatment, care, services, or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Related to Intake #002865-17:

The Director of Care submitted a Critical Incident Report (CIR), on an identified date, for an alleged incident of neglect. The neglect incident occurred the previous day, and involved resident #021.

The Director of Care indicated, to Inspector #554, that resident #021 was assisted by identified staff to bed, at an approximate hour on the identified date. Resident #021 was not provided care, and food and fluid intake for an identified period of time.

The clinical health record, for resident #021, was reviewed by Inspector #554.

Progress notes indicated the following for the identified date:

- Personal Support Workers assisted resident to bed at an identified hour. Resident went to sleep and remains in bed.
- Resident slept through meals on an identified shift.
- Resident #021 was received in bed at an identified hour, resident was asleep. Approximately two and a half hours later, Registered Practical Nurse (RPN) #112 observed resident to be stirring, and directed Personal Support Workers (PSW) to get resident up. Two and a half hours later, a PSW came to Registered Practical Nurse #112 stating they had just got resident up, and that resident was soiled, and in still in an identified product from an identified shift. PSW's indicated the bed, of resident #021, was soiled. The progress note indicated that resident has not been provided intake.

Registered Nurse (RN) #116, who was the Charge Nurse on shift the identified shift, indicated in his/her statement to the Director of Care, that he/she had heard resident #021's safety device alarm ringing at an identified hour, and observed two PSW's providing care to resident #021. RN #116 indicated (to the Director of Care) that resident #021 was still in the continence product from an identified shift, and that the continence product and the resident's bed were soiled. RN #116 indicated (to the Director of Care) that there had been no mention in shift report, from the previous shift, of resident #021 being in bed.

The Director of Care indicated, to Inspector #554, that RN #116 had left him/her a voice message, on his/her (DOC) office phone, indicating that resident #021 had not received care, and further detailed how resident had been found on the identified date by staff.

The Director of Care indicated, to Inspector #554, that failure to provide care, and intake constitutes neglect of care. The Director of Care indicated that RN #116 should have immediately notified the Director.

Registered Nurse #116 was not available for an interview during this inspection.

Registered Nurse #116, who was the Charge Nurse on the identified date, failed to ensure that neglect of resident #021 by staff was immediately reported to the Director. [s. 24. (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 there is a process in place and monitored, ensuring that abuse and neglect of a resident is immediately reported to the Director, to be implemented voluntarily.

WN #4: 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. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training, specifically related to, the Resident Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect

of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26.

Under LTCHA, s. 76 (1) - Every licensee of a long-term care home shall ensure that all staff at the home have received training as required by this section.

Related to Intake #002865-17:

Critical Incident Report (CIR), submitted by the Director of Care, indicates that Personal Support Workers (PSW) #113, 114, Registered Practical Nurse (RPN) #111, and 112, and Registered Nurse (RN) #116 had been involved directly or indirectly with the alleged neglect of resident #021. The neglect incident occurred on an identified date.

The Director of Care indicated, to Inspector #554, that the identified Personal Support Workers, Registered Practical Nurses, and Registered Nurse, all had been hired in during months in 2016 and 2017. The Director of Care indicated that the identified staff had not received training specific to Resident Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26, upon hire, and or prior to performing their responsibilities. The Director of Care indicated that there is no documentation to support that the identified staff had been provided training.

Registered Practical Nurse #111 indicated, to Inspector #554, that he/she does not recall being provided training, specific to the above, during orientation. Registered Practical Nurse was not aware of Section 24, nor was he/she aware of reporting requirements related to the same.

Personal Support Workers #113, 114, Registered Practical Nurse #112, and Registered Nurse #116, were not available for an interview during this inspection.

The Director of Care indicated that new staff hires are provided a package to read, which would include Zero Tolerance of Abuse and Neglect, Resident Bill of Rights, but there is no follow up with new staff to ensure that they have read the information and signed off on the general orientation checklist prior to performing their responsibilities.

As of this inspection, the Director of Care indicated that there is no documentation to support that Personal Support Worker #114, and Registered Practical Nurse's #111 and #112 have received training, specific to the above requirements.

The licensee failed to ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training, specifically related to, the Resident Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26. [s. 76. (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 there is a process in place and monitored, ensuring that no person mentioned in subsection (1) performs their responsibilities before receiving training, specifically related to, the Resident Bill of Rights, the long-term care home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and the protections afforded by section 26, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that following the quarterly review of all medication incidents and adverse drug reactions that have occurred in the home, that a written record was kept of any changes and improvements identified in the review and when or if those changes and improvements were implemented.

The Professional Advisory Council (PAC) meeting minutes for two identified dates were provided to Inspector #624, documentation of the quarterly review of all medication incidents and adverse drug reactions that had occurred in the long-term care home for the second and third quarters of 2017.

A review was completed of both PAC meeting minutes, both of which referred to medication incident summaries and a quarterly report from the Clinical Consultant Pharmacist. None of these documents indicated or documented any changes and improvements identified from the quarterly reviews and whether or not any changes or improvements were implemented to prevent reoccurrence of the medication incidents.

In an interview with the DOC, he/she indicated, to Inspector #624, that during the quarterly reviews, the staff, Physician and Consultant Pharmacist usually discuss ways of reducing the medication incidents and the registered nursing staff work closely with the pharmacy as well as the Physician to implement suggested strategies. After reviewing both PAC meeting minutes, the DOC indicated that both reports do not have any record of changes and improvements identified during the reviews and whether or not those changes were implemented. [s. 135. (3)]

Issued on this 4th day of January, 2018

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

Original report signed by the inspector.