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 # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2017	2017_615638_0024	022179-17	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 KIRKLAND LAKE
155 GOVERNMENT ROAD EAST P.O. BAG 3900 KIRKLAND LAKE ON P2N 3P4

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

RYAN GOODMURPHY (638), SHELLEY MURPHY (684)

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): November 20 - 23, 2017.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, acting Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aids, residents and their families.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs and resident health care records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

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

During a family interview with Inspector #684, resident #004 was identified as having a lack of choices in their daily dressing routines.

Inspector #684 reviewed resident #004's health care records and identified in their care plan, specific instructions related to the resident's closet.

The Inspector noted a progress note written in Point Click Care (PCC) in October 2017, which indicated that resident #004 was continually requesting to access their clothing.

During a room observation, Inspector #684 noted on November 22 and 23, 2017, resident #004's closet contrary to the instructions identified in the resident's care plan.

In an interview with Inspector #684 PSW #104 identified why resident #004's closet was observed contrary to the instructions documented in the resident's plan of care.

Inspector #684 interviewed RPN #103 who stated that resident #004's care plan indicated their closet was to be in the state as directed on the resident's care plan. The Inspector reviewed the interventions being implemented (contrary to the instructions in the resident's care plan) with the RPN and they indicated that the care plan in place and the interventions being implemented were not the same.

The home's policy titled "Care Planning - RC-05-01-01" last revised April 2017, indicated that the plan of care consists of a series of documents that provide information and instructions to the care team regarding the assessed needs, delivered care and outcomes of care.

During an interview with Inspector #684, the Inspector reviewed resident #004's care plan with the acting Administrator and acting DOC. The Inspector then shared their observations and the rationale provided by direct care staff. The acting Administrator and acting DOC indicated that staff should have followed the resident's plan of care. [s. 6. (7)]

2. Resident #005 was identified as having a specific continence care intervention through their Minimum Data Set (MDS) assessment.

Inspector #638 reviewed resident #005's health care record and identified a physician order created on a specific date in June 2017, which provided specific care interventions regarding the specific continence care intervention. The Inspector reviewed the resident's electronic treatment administration record (eTAR) and identified in September 2017, that registered staff documented the specific care intervention as "5" (5=Hold/See Nurse Notes). The Inspector reviewed the progress notes and was unable to identify any notation regarding the resident's specific care interventions for the specific continence care intervention throughout the month of September 2017.

Inspector #638 reviewed the September 2017, eTAR notation with the RPN #103, who stated that there should have been a progress note explaining why the care had not been provided. The RPN was unable to identify any notation within the progress notes or shift report binder in September 2017, indicating why registered staff did not complete the required specific care for the specific continence care intervention.

During an interview with Inspector #638, the acting Administrator and acting DOC, the Inspector reviewed resident #005's eTAR for September 2017, with the acting Administrator and acting DOC, which indicated that the specific care for the specific continence care intervention was held. The acting Administrator indicated that the specific care intervention should have been completed as per the physician orders as there was no rationale or documentation supporting why the change did not occur. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, a goal

in the plan was met.

Resident #002 was identified as having a specific continence care intervention related to specific diagnoses during a staff interview with RPN #101.

Inspector #638 reviewed resident #002's health care records on November 22, 2017, and identified in their care plan that the resident required a specific continence care intervention related to specific diagnoses. The goal for the foci indicated that the specific diagnoses would resolve in ten days.

The Inspector reviewed the physician orders and identified an order in November 2017, which directed staff to initiate specific treatment for the resident's diagnosis for seven days. Upon reviewing the resident's electronic medication administration record (eMAR), the Inspector identified that the resident had finished their specific treatment.

In an interview with Inspector #638, RPN #101 indicated that whenever there was a change in a resident's needs, registered staff would update the care plan to portray the resident's care needs. The RPN stated that registered staff should check the care plan upon completion of any treatment to ensure that the care plan was kept up to date. The Inspector reviewed resident #002's care plan with RPN #101 who indicated that the goal indicating that the resident's specific diagnosis would resolve in 10 days should have been removed after the completion of the specific treatment.

The home's policy titled "Care Planning - RC-05-01-01" last revised April 2017, indicated that the team was to ensure that the care plan is revised when appropriate to reflect the resident's current needs, based on evaluation of progress towards goals.

During an interview with Inspector #638, the acting Administrator and acting DOC indicated that care plans were to be updated when there was a change in the resident's status. They indicated that when a resident's care plan "goal" was met, the care plan should be updated and that goal removed. The Inspector reviewed resident #002's care plan with the acting Administrator and acting DOC who stated after the specific treatment was completed, the registered staff should have reviewed the resident's care plan and removed the goal that was met. [s. 6. (10) (a)]

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 residents are reassessed and their plan of care reviewed and revised when a goal in the plan is met, to be implemented voluntarily.

WN #2: 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 each resident of the home had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the care of new items.

During the initial tour on November 20, 2017, Inspector #684 identified a used and unlabelled set of nail clippers in the tub room on the third floor.

Inspector #638 observed a used and unlabelled urinal and comb in a shared bathroom between two rooms. The Inspector also identified a used and unlabelled urinal stored in a shared bathroom in a second room. The Inspector observed the aforementioned used and unlabelled items again two consecutive days later.

In an interview with Inspector #638, RN #109 indicated that all resident personal items should be labelled. The Inspector observed the used and unlabelled urinal and comb in one room and the used and unlabelled urinal in a second room with the RN, who indicated that these items should have been labelled. The RN indicated if there were unlabeled personal items and staff were unsure who they belonged to, staff would dispose of the items and new items would be obtained and labelled for the resident.

The homes policy titled "Resident Care Equipment - RC-07-01-01" last revised April 2017, indicated that all resident personal care items would be labelled within 48 hours of admission and upon acquiring new items. The policy further identified that certain items posed immediate risk to residents. These were classified as items that came in contact with body fluid (urine/faeces) or other items contaminated with particularly or highly transmissible microorganisms, or items (bedpans, urinals and commode pans) to be used on highly susceptible residents.

During an interview with Inspector #638, the acting Administrator indicated that resident personal belongings should be labelled. The Inspector reviewed the previously observed items in the shared bathrooms with the acting Administrator, who indicated that these items should have been labelled to ensure residents were not sharing personal items. [s. 37. (1) (a)]

WN #3: 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 has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Inspector #684 reviewed medication incident records provided by the acting Administrator and acting DOC. During the review the Inspector noted that there was no documentation supporting a quarterly review of the medication incidents for the past quarter.

The home's policy titled "Medication Incident Reporting Policy and Procedures - RC-16-01-09" last revised February 2017, indicated that a review of all medication incidents, adverse drug events and corrective action plans would take place at the home's Medical/Professional Advisory Committee. They would also evaluate and audit the medication incident reporting policy to ensure compliance and identify opportunities for quality improvement.

In an interview with Inspector #684, the acting Administrator informed the Inspector that they did not have the past two quarterly reviews of the medication incidents. The acting Administrator indicated that the last quarterly review they could locate was from February 2017. [s. 135. (3)]

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Issued on this 29th day of November, 2017

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

Original report signed by the inspector.