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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 4, 2020	2020_680687_0003	000973-20	Other

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 Kirkland Lake
155 Government Road East KIRKLAND LAKE ON P2N 3P4

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

LOVIRIZA CALUZA (687), AMY GEAUVREAU (642)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): January 27 to 31, 2020.

This inspection is a Sudbury Service Area Office Initiated Inspection (SAO II).

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC)/Clinical Coordinator, Wound Care Coordinator, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Restorative Care PSW, Office Manager, Nursing Clerk and residents.

The Inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Medication
Reporting and Complaints
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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,
(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 that a resident who was 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.

a) During the Sudbury Service Area Office Initiated Inspection (SAO II), Inspector #687 reviewed the home's binder entitled "Data Tracking Tool 2020". The Inspector identified resident #002 with skin impairment to a specified area.

In an observation conducted by Inspector #687, resident #002 was observed with a specific intervention to a specified area.

In a review of resident #002's electronic progress notes, Inspector #687 identified that resident #002 had returned from a specified facility with a specific skin impairment to a specified area on a specified date.

A review of the resident #002's Skin and Wound Weekly Assessment Record, Inspector #687 identified resident #002 had a specific skin impairment on a specified date which they sustained from a specified facility. However, the Inspector did not identify any further skin and wound weekly assessment regarding the resident's specific skin impairment on

the specified dates.

In a review of the home's policy titled "Skin and Wound Program: Wound Care Management" last updated December 2019, it indicated that, "A resident exhibiting any form of altered skin integrity would received a skin assessment by a Nurse using a clinically appropriate assessment instrument that was specifically designed for skin and wounds and be reassessed at least weekly by a Nurse if clinically indicated".

During an interview with Personal Support Worker (PSW) #108, they verified that resident #002 had a specific skin impairment to a specified area and had a specific intervention.

In an interview conducted by Inspector #687 with Registered Nurse (RN) #105, the RN stated that resident #002 currently had a specified skin impairment and stated that the Wound Care Coordinator (WCC) would be able to provide further details.

During an interview with the WCC, they stated that resident #002 currently had a specific skin impairment to a specified area. The WCC verified that there were no weekly skin and wound assessments completed for resident #002 for approximately six weeks on the specified dates.

In an interview with the Assistant Director of Care (ADOC), they verified that resident #002 had a specific skin impairment to a specified area and stated that the Weekly Skin and Wound Assessment was not completed for approximately six weeks on the specified dates.

b) Inspector #687 further identified resident #008 with a specified skin impairment.

In a review of the home's binder titled "Data Tracking Tool 2020". Inspector #687 identified resident #008 with a specific skin impairment to a specified area.

A review of resident #008's electronic progress notes, indicated that on a specified date, resident #008 was identified with a specific skin impairment to a specified area.

During an observation conducted by Inspector #687, resident #008 was observed with a specified intervention.

In a review of resident #008's Skin and Wound Weekly Assessment Record, Inspector

#687 did not identify a weekly skin and wound assessment on the specified dates.

During an interview with PSW #117 and RN #113, they verified that the resident had a specific skin impairment to a specified area and specific interventions were in place.

In an interview with the Registered Practical Nurse (RPN) #119, they stated that resident #008 was previously identified with a specific skin impairment to a specified area. The RPN further stated that the resident's weekly skin and wound assessment was last completed on a specified date.

In an interview with the Administrator, they verified that resident #008 had a specific skin impairment to a specified area and that a weekly skin and wound assessment was last completed on a specified date. The Administrator further stated that the Registered Staff should have had completed the succeeding weekly Skin and Wound Assessment approximately around a specified date, but it was not completed. [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 that a resident who is exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there were a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

During the SAO II, Inspector #642 had reviewed the home's complaints and reporting process.

Inspector #642 had reviewed a document from a specified date titled, “Complaint Investigation Form.” It was identified that resident #007’s enacted Substitute Decision Maker (SDM) had provided a verbal complaint to the Director of Care (DOC) which stated that they [enacted SDM] had requested for the resident’s specified continence care product be changed on the specified date. The document further identified that resident #007’s enacted SDM indicated that RN #115 had informed them that there were no supplies to replace the specified continence care product but it was ordered.

The Inspector reviewed the policy titled, "Continence Management Program" revised date December 2019, which indicated that the home would facilitate the provision of a reasonable range and sufficient quantity of incontinence products and were to ensure that it was readily accessible to residents and direct care staff.

During a review of the electronic progress notes for resident #007 on a specified date, Inspector #642 identified an entry by Nurse Practitioner (NP) #120 which indicated directions regarding the resident's specified continence care supply.

Inspector #642 interviewed resident #007 and their enacted SDM, who both stated that the home had been out of supply of the specified continence care product for resident #007 two or three times prior to the specified date. The enacted SDM further stated that they had previously went to a nearby facility to obtain the specified continence care supply required for the resident’s product change.

In an interview with Nursing Clerk #118, they stated that they were usually informed by the nurses when to re-order resident #007’s specified continence care supply. The Nursing Clerk further stated that resident #007’s specified continence care supply had run out due to a miscommunication with the nurses on a specified date.

Inspector #642 interviewed RPN #111, who stated they had run out previously of resident #007’s specified continence care supply and had to obtain the specified continence care product from a specified facility. The RPN further stated that the resident required a

specific continence care product due to a specified risk.

In an interview with RN #115, they verified that they were working on the specified date. The RN spoke to resident #007's enacted SDM to informed them that there were no available supplies for the resident's continence care product and that that the enacted SDM was upset. The RN further stated that specified continence care interventions were performed but the home did not have the required continence care supply for the resident on that date.

During an interview with the DOC they stated that the specified continence care products were part of the home's Continence Care program and that supplies should be readily available for their residents. The DOC further stated that there was a miscommunication regarding the supply management of resident #007's specified continence care product and acknowledged that they had run out of supply at that time. [s. 51. (2) (f)]

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 there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that that the written plan of care for a resident set out clear directions to staff and others who provided direct care to the resident. s. 6 (1) c.

In an observation conducted by Inspector #687, resident #008 was observed with a specified intervention when they were up in their mobility device.

A review of resident #008's current electronic Care Plan Record in effect at that time, Inspector #687 identified specific interventions under the task focus "Impaired Mobility and Functioning".

In an interview with the PSW #117, they stated that they used a specific intervention when resident #008 was up in their mobility device. The Inspector and the PSW reviewed the resident's current electronic Care Plan Record in effect at that time and the PSW identified that the resident's care plan did not indicate a specific direction when the resident was up in their mobility device. The PSW further stated that the care plan did not provide them with clear direction.

In an interview with Restorative Care PSW, they stated that resident #008 used a specific intervention when the resident was up in their mobility device. The Inspector and the Restorative Care PSW reviewed the resident's current electronic Care Plan Record in effect at that time and indicated that the care plan should have been updated to reflect their documentation. The Restorative Care PSW further stated that the resident's care plan focus regarding the use of the specified intervention did not provide clear direction to staff members.

In an interview with the RN #113, they verified that resident #008 used a specific intervention when the resident was up in their mobility device. The Inspector and the RN reviewed the resident's electronic Care Plan Record in effect at that time and the RN stated that the resident's current electronic care plan regarding the specified intervention did not provide proper direction to staff members.

During an interview conducted by Inspector #687 with the Administrator, the Administrator stated that the staff had utilized a specified intervention for resident #008. The Administrator further stated that the resident's electronic care plan in effect at that time should have had provided clear direction to the staff members regarding the specified intervention as this created confusion when the resident was up in their mobility device. [s. 6. (1) (c)]

Issued on this 5th day of February, 2020

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

Original report signed by the inspector.