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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 23, 2016	2016_328571_0025	013462-16	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 LAKEFIELD
19 FRASER STREET P. O. BOX 910 LAKEFIELD ON K0L 2H0

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

PATRICIA MATA (571), DENISE BROWN (626)

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): September 6, 7, 8, 9, 12, 13, 14, 2016

During this Resident Quality Inspection the following Critical Incident logs were inspected: 025222-16, 027259-16 related to resident to resident abuse; 027131-16 related to call bell system failure.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Infection Control Lead, residents and family members.

In addition, the following was reviewed: clinical health records, administrative records, and several licensee policies. Observations were also made over several days.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home

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

2 WN(s)
0 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 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 failed to ensure that each resident has his or her personal items labelled within 48 hours of admission and when acquired r. 37(1) (a).

During the initial tour of the home on September 6, 2016, unlabelled personal items were observed in two Spa rooms in the home. One unlabelled nail clipper was observed on the counter in the Spa room located in Trent House. In the Spa room on Kawartha House, on the same day, one unlabelled nail clipper was found in the cupboard, one unlabelled bar of soap and one blue unlabelled hair brush was observed on the counter. On September 14, 2016,one unlabelled nail clipper was found in the cupboard in the Kawartha House Spa room . On the same day in the Stoney house Spa room two unlabelled nail clippers were found on the counter.

In an interview on September 14, 2016, PSW #117 and #118 both indicated that nail clippers must be labelled and kept in each resident's individual basket which contains personal items. During an interview on September 14, 2016 with RN #116, the Infection Control Lead, she confirmed that the nail clippers must be labelled and kept in the resident's personal bin.

Therefore, the licensee failed to ensure that all residents' personal items are labelled. [s. 37. (1) (a)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that for a resident taking any drug or combination of drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #013 has several specified diagnoses.

A review of the clinical record indicated that on a specified date, the Physician for resident #013 ordered an new opioid analgesic. After review of the resident's clinical record, no evidence of documentation regarding the resident's response to and the effectiveness of the new opioid analgesic could be found.

In an interview on September 13, 2016, RPN #112 indicated that his/her practice was to do a 72 hour pain assessment in the licensee's electronic clinical record when a resident is started on a new analgesic. In a separate interview on the same date, the DOC acknowledged that when a new analgesic is ordered, staff are to do assessments for at least 72 hours.

Therefore, the licensee failed to ensure monitoring and documentation of the resident's response and the effectiveness of a drug was completed when resident #013 was started on a new opioid analgesic. [s. 134. (a)]

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Issued on this 23rd day of September, 2016

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

Original report signed by the inspector.