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
Apr 1, 2022	2022_885601_0004	014289-21	Complaint

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 Lakefield
19 Fraser Street Lakefield ON K0L 2H0

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 28, March 1, 2, 3, and 4, 2022.

The following intakes were completed in this Complaint Inspection:

A log related to allegations of neglect, and care concerns.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

The inspector also reviewed resident clinical health care records, relevant home policies and procedures, observed the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Pain

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's Physician or Nurse Practitioner (NP) and each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other when the resident's medication was held by the nurse.

The Ministry of Long-Term Care received a complaint that the resident had a decline in their medical condition and concerns with how the resident's symptoms were managed.

Record review of the resident's Medication Administration Record (MAR) identified that the resident was prescribed medication to mange their medical condition. The resident's medication was not administered to the resident as prescribed by the physician on several occasions over several months. Record review identified the resident was experiencing symptoms when the medication was held by the nurse. The resident's medical status was at risk as there was no evidence that the resident's Physician or the Nurse Practitioner was notified that the resident's medication was held by the registered staff, nor that the Physician or the Nurse Practitioner were updated on the resident's medical condition when the medication was held by the nurse. The DOC acknowledged that registered staff should have notified the Physician or the Nurse Practitioner for direction when the resident was experiencing symptoms and the medication was withheld.

Sources: Record review of the resident's Medication Administration Record (MAR), Physician Orders, Progress Notes, and interview with the Director of care (DOC). [s. 6. (4) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with the resident's Physician or Nurse Practitioner (NP) and each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other when the resident was experiencing symptoms of infection.

The Ministry of Long-Term Care received a complaint that the resident had a decline in their medical condition and concerns with how the resident's infections were managed.

The resident had symptoms of an infection and a decline in condition over several days, and there was no documentation of an assessment completed for the resident on two of the days. On day four the resident had symptoms of infection and the resident's SDMs expressed concern regarding the resident's decline in condition and requested further assessment. The resident was diagnosed with an infection and required treatment outside of the facility. According to the Director of Care (DOC), the home received a complaint from the resident's Substitute Decision Maker (SDM) and the internal investigation determined that on two days, the resident had a symptom of infection, and the registered nurse didn't assess the resident nor communicate the resident's condition with the resident's Physician or SDM.

On another occasion, the resident's Substitute Decision Maker (SDM) requested the resident be assessed by the Physician due to the resident having symptoms of an infection. Record review of the resident's Medication Administration Record (MAR) identified the registered staff had held the resident's medication for a medical condition as the resident was experiencing symptoms related to the medication. The NP assessed the resident and ordered some test to determine the cause of the resident's decline in condition. The NP documented the resident was experiencing a significant change in condition over the past few weeks. Two days later the resident was diagnosed with an infection and required treatment outside of the facility.

The resident was at risk for a decline in medical condition when the registered nurse did not collaborate with the resident's Physician or NP to report the resident's symptoms of infection on two separate occasions.

Sources: Review of the resident's progress notes, and interview with the DOC. [s. 6. (4) (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 ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1.The licensee has failed to ensure that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls when the resident had an unwitnessed fall.

O. Reg. 70/10, s. 48 (1) 1 required the home to have an interdisciplinary falls prevention and management program developed and implemented in the home, with the aim to reduce the incidence of falls and the risk of injury.

The Ministry of Long-Term Care received a complaint that the resident’s care needs were not being met.

The resident had an unwitnessed fall and was assessed with no injuries. The licensee’s post fall management policy directed to complete a post fall assessment that included the initial physical and neurological assessment. When a fall was unwitnessed, the clinical monitoring post fall included to complete the resident’s neurological vital signs, vital signs, assess for pain and change of behaviour every hour for four hours and then every eight hours for 72 hours. The policy also directed to notify the physician or Nurse Practitioner (NP) if there was a sudden change in vital signs and/or neurological assessment. The resident was at risk when their post fall assessment was incomplete, and the hourly neurological assessment was incomplete, and the resident was experiencing a decline in medical condition.

There was no evidence to support that the Physician or NP had been made aware of the resident’s unwitnessed fall or ordered the neurological assessment to be discontinued when the resident had a decline in their medical condition. The Director of Care (DOC) confirmed that the resident’s post fall assessment and the neurological clinical monitoring record was initiated but not completed, as per the licensee’s policy.

Sources: Review of the licensee’s Fall Prevention and Management Program policy, the resident’s care plan, progress notes, post fall assessments, and interview with the DOC. [s. 49. (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 ensure that the following interdisciplinary programs are developed and implemented in the home: (2) Each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure the system to monitor and evaluate resident #001's food and fluid intake was implemented when the resident was identified with risks related to nutrition and hydration.

The resident was identified as a high nutritional risk due to a medical condition and they did not have their food and fluid intake monitored and evaluated. A record review identified several days with incomplete documentation of the resident's daily food and fluid intake records. Staff interviews identified the PSWs were to alert registered staff if the resident had decreased food and fluid intake and to document the resident's food and fluid intake electronically in point of care (POC). The Director of Care (DOC) acknowledge there was no way to monitor and evaluate the resident's nutritional status when the POC documentation was incomplete. The resident was at risk for fluid imbalances and nutritional risk when the resident's food and fluid intake was not monitored and evaluated due to there being several gaps in the documentation.

Sources: Review of the resident's progress notes, care plan, quarterly nutritional assessment's, POC documentation, Food and Fluid Intake Monitoring policy, and interviews with PSWs, Registered Staff and the DOC. [s. 68. (2) (a)]

2. The licensee has failed to ensure the system to monitor and evaluate resident #002's food and fluid intake was implemented when the resident was identified with risks related to nutrition and hydration.

The resident was identified as a high nutritional risk and their food and fluid intake was not monitored and evaluated. A record review identified several days with incomplete documentation of the resident's daily food and fluid intake records. Staff interviews identified the PSWs were to alert registered staff if the resident had decreased food and fluid intake and to document the resident's food and fluid intake electronically in point of care (POC). The Director of Care (DOC) acknowledge there was no way to monitor and evaluate the resident's nutritional status when the POC documentation was incomplete. The resident was at risk for fluid imbalances and nutritional risk when the resident's food and fluid intake was not monitored and evaluated due to several gaps in the documentation.

Sources: Review of the resident's progress notes, care plan, POC documentation, Food and Fluid Intake Monitoring policy, and interviews with PSWs, Registered Staff and the Director of Care. [s. 68. (2) (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 ensure that the programs include, (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration, to be implemented voluntarily.

Issued on this 6th day of April, 2022

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

Original report signed by the inspector.