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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 24, 2014	2014_360111_0017	O-000526-14	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

LYNDA BROWN (111), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)

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): June 17-20 & 23-26, 2014

A Critical incident and complaint was also inspected concurrently during this inspection (log# 000517 & 001037)

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurse (RPN), Personal Support Workers (PSW), Registered Dietician, Resident Program Manager, Physiotherapist, Physiotherapy Assistant (PA), Housekeeping Manager, Housekeeper (HSK), Environmental Manager, Dietary Manager, Dietary Aides (DA), Resident Care Coordinator (RCC), RAI-Coordinator, Resident Council President, Family Council President, Residents and Families.

During the course of the inspection, the inspector(s) Reviewed health records of current and deceased residents, reviewed Resident and Family Council Meeting Minutes, Reviewed the homes policies (Infection Control, Pain, PASD, Skin and Wound, Restraints, Personal Hygiene and grooming, Palliative Care, Responsive Behaviours, Weights, Resident Abuse, and Complaints),Food Committee Meeting Minutes, Food temperature Records, Staff Training record,and Staff screening records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Hospitalization and Death
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

The licensee failed to ensure that the resident requiring end-of-life care received care in a manner that met the resident's needs, specifically to remain in bed with repositioning.

Review of the progress notes for Resident#835 indicated the resident had deteriorated and was deemed Palliative on a specified date.

Review of the care plan for Resident #835 indicated "palliative measures" and the resident was dependent on staff for all aspects of care, and the resident was to be turned every two hours in bed.

Observation of Resident #835 noted:
- 7 days before death during an 8 hour time period, the resident remained lying on their back with no evidence of repositioning.
- 5 days before death, the resident was found sitting in a wheel chair, fully clothed in day clothing, and sitting in the dining room with a plate of food in front of the resident while the resident remained unresponsive. A staff member attempted to feed the resident breakfast and was heard stating "I guess tired today".

Staff Interviews indicated the following:
- Staff #112 indicated the resident was not turned while in bed on the specified date because the resident "was on a special mattress".
- Staff #133 indicated the resident was assisted out of bed, dressed and taken to breakfast on a specified date as the staff member was not aware the resident was palliative and was directed by Staff #118 to take the resident to the dining room for breakfast.
- Staff #118 indicated direction was given to Staff #133 to take the resident to the dining room as resident was already out of bed and was not aware of the resident's change in health status. The resident was then returned to bed.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 :

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs of the resident related to a prosthetic.

Observation of Resident#841 on 5 specific dates noted a thick, green discharge covering the resident's prosthetic.

Interview of staff:
-Staff #112 indicated the resident frequently has infections related to the prosthetic.
-Staff #118 indicated the resident's prosthetic had not been removed for several years, frequently has infections, and which the physician does not like to treat. The staff member indicated one treatment is occasionally used to decrease discharge from the prosthetic.

Review of the care plan for Resident #841 indicated the resident had a prosthetic device and required extensive assistance with personal hygiene. There was no interventions to manage the presence of the prosthetic and no documented evidence of any assessments related to the resident's prosthetic.[s.6(2)]

2. The licensee failed to ensure that the care set out in the plan of care was based on an
assessment of the resident and the needs of the resident related to personal grooming and bathing.

Observation of Resident #842 on two specified dates indicated the resident had not received facial grooming.Three days later the resident had received facial grooming.

Review of the bath list indicated Resident#842 has 2 bath days.

Review of care plan for Resident #842 indicated under personal hygiene: limited

assistance, staff to provide appropriate assistance. Under bathing: prefers tub bath, extensive assistance x 1 staff with bathing process and clean/trim/file fingernails weekly.

Interview of Resident#842 indicated the facial grooming was usually completed on bath days but was missed because it was dependent on which staff were working. The resident indicated the facial grooming was completed on the second bath day.[s. 6. (2)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to weight loss.

Review of the nutritional progress notes for Resident #841 indicated the resident had sustained significant weight loss, was below goal weight range, and had a weight loss of 10% in six months related to poor meal and fluid intake despite ++ staff encouragement and the resident received multiple supplements to help minimize weight loss.

Review of the Resident #841 care plan indicates the resident is a high nutritional risk due to variable intake, significant weight loss and poor dentition. Interventions included:providing as needed (PRN) dietary supplement if resident consumes less than 50% of meal or refuses meal.

Review of Resident#841 meal intake for 1 month period indicated the resident refused meals 39 times;consumed 0-25% of meal 26 times; consumed 26-50% of meal 12 times and consistently refused snacks.

Interviews with staff indicated Staff #118 was not aware of the process for administration of PRN dietary supplements; Staff #125 indicated they notified the nurse if the resident had poor intake or refused a meal so they could administer a dietary supplement; Staff #124 indicated that the PRN dietary supplement would be administered by registered staff and recorded on the Medication Administration Record (MAR)when given but that the PSW's rarely reported the resident as having consumed less than 50% of a meal or refusing a meal.

Review of the MAR for the same time period had no indication the dietary supplement had ever been administered despite the resident refusing meals 39 times and consuming less than 50% of meals 38 times, during that same time period. [s. 6. (7)]

4. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to responsive behaviours.

Observation of Resident #859 over a nine day period during specific time periods, indicated the resident demonstrated constant responsive behaviours. The resident was offered one of the interventions as indicated in the plan once on five of those days and a second intervention only once to manage the responsive behaviours. Several staff were observed by all 4 Inspectors to walk past Resident #859 room, on 8 out of 9 days despite the resident calling out for assistance.

Review of Resident #859 care plan identifies the responsive behaviours and there were several interventions included to manage the resident's responsive behvaiours.

The Behavioural Support Ontario (BSO) board (located at the nursing station) identifies additional interventions to manage the resident's responsive behaviours.

Interviews with staff working on the unit with Resident #859 indicated the following:
-Staff #112 indicated BSO staff will occasionally utilize interventions as indicated in the plan of care but that they work limited hours and must provide support to all residents with responsive behaviours during that limited time.
-Staff #113, was uncertain as to which staff utiltized the interventions to manage the resident's responsive behaviours or when interventions where utilized.
-Staff #135 indicated unaware of interventions to manage the constant responsive behaviour demonstrated.

Two of the strategies identified to manage the resident's responsive behaviours were not observed during most of the observation dates. On one of the observation dates, a staff member was observed providing an intervention that was contraindicated to a strategy in the plan of care and the strategy of referral to PASE was last completed approximately greater than a year ago despite ongoing demonstration of responsive behaviours and indicated as a strategy to manage the responsive behaviours. [s. 6. (7)]

5. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to oral hygiene and dressing.

Observation of Resident #778 on over three days noted oral hygiene had not been

provided. During the same time period, the resident was also observed with edematous lower limbs.

Review of the care plan for Resident #778 indicated staff were to provide oral hygiene and apply appropriate treatment to the lower limbs.

Interview of staff indicated the following:
-Staff #113 had no knowledge the treatment to the lower limbs and indicated the resident performed their own oral hygiene.
-Staff #118 indicated that resident did not have the appropriate treatment to the lower limbs in place due to alteration in skin integrity.

Review of the progress notes for Resident #778 indicated the resident had altered skin integrity but no contraindication to the appropriate treatment to the lower limbs.[s. 6. (7)]

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 the written plan of care for each resident is based on the assessed needs of the resident, and the care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that when the resident demonstrated responsive behaviours, the behavioural triggers were identified, where possible.

Observation of Resident #859 during an 8 day period indicated the resident demonstrated constant responsive behaviours.
Interview with Resident #859, indicated the resident had specific triggers that resulted in the responsive behaviours.

Review of the progress notes for Resident #859 for a two month period, indicated most of the responsive behaviours that were demonstrated during the 8 day period.

Interview of Staff #113 and #133, were not aware of the triggers related to Resident#859 responsive behaviour.

Review of Resident #859 care plan only identifies triggers for the responsive behaviours as "due to environment", phone at care centre and hunger. There were no other triggers identified for the responsive behaviours exhibited by resident #859. [s. 53. (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 to ensure that each resident demonstrating responsive behaviours, has behavioural triggers identified where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

The licensee failed to ensure that residents admitted to the home were screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission.

Review of health record indicated:
Resident #872- did not have TB screening completed until 3 months after admission.
Resident #873- did not have TB screening completed until 4 months after admission.
[s. 229. (10) 1.]

2. The licensee failed to ensure that residents were offered immunizations against pneumoccocus, tetanus and diptheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Review of health care records for the following residents indicated:
-Resident #870, #868, #872 & #873 had no evidence of tetanus, diptheria or pneumovax offered.[s. 229. (10) 3.]

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 all residents admitted to the home are screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission, and that all residents are offered immunization against pneumoccocous, tetanus and diptheria in accordance with the publicly funded immunization schedules, to be implemented voluntarily.

WN #5: 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 :

The licensee failed to ensure the homes policy of "Skin Treatments" was complied with.

Under O. Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Review of the homes' policy "Skin Treatments (#03-05) and Stasis Ulcers, Surgical and Other Wounds (#03-08)", indicates the treatment administration record is used to document the application and completion of the treatment and the care plan is to be updated to indicate the location of the skin alteration, and interventions/treatments required.

Resident #778 was observed on a specified date with an intact dressing in place and the same dressing was observed still intact 12 days later.

Review of the progress notes for Resident #778, indicated the resident sustained a skin tear and the resident was initially assessed and a dressing applied. There were no further documented evidence of weekly assessments noted.

Review of the Treatment Administration Record (TAR) during the time the injury was sustained, had no documented evidence of a treatment applied.

Review of the care plan for that same period, did not identify the resident as having a skin tear or any interventions to manage the alteration in skin integrity. [s. 8. (1)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

The following observation were noted by Inspector #570:
-Resident #791, #799, and #837's wheelchair was noted to be soiled for more than one day.

Interview of the Housekeeping Manager and RPN#124 indicated that walkers/wheelchairs are cleaned by night staff and are to be cleaned as per the posted cleaning schedule.

Review of wheelchair cleaning schedule for the resident's identified indicated the wheelchair's were to be cleaned during the same observation period but there was evidence to indicate that the wheelchair was cleaned (as per posted schedule). [s. 15. (2) (a)]

2. The following were observations were noted for a 4 day period:
- brown stains or discolouration visible at the base of the toilet and around the grout/sealant in rooms #228, 230, 231, 236, 302, 325, 332, 334, 401,406, 409, 431 and Kawartha tub and shower room toilets.
- the hallways carpeting had several visible stains throughout Kawartha unit (especially near rooms 313,316,328,332,333,336) and on Trent unit (outside of 407, 409, 412).

Interview of Staff #122 indicated that the resident rooms and washrooms were cleaned on a daily basis; floors are dry mopped daily and washed as required.
An interview of the Administrator, Staff #121 and #122, indicated that the housekeeping department does spot clean the carpets when soiling is noted and has

a schedule in place for deep cleaning of the carpets. The Administrator indicated that Kawartha units would be deep cleaned [s. 15. (2) (a)]

3. The licensee failed to ensure that the home, furnishings and equipment are maintained in a safe condition and a good state of repair which is a potential risk to the health, safety and well-being of residents.

The following observations were noted:
-On June 18, 2014 Resident #791 wheelchair had two worn out(chipped and rough) wheels.
-On June 19, 2014 Resident #802 wheelchair has two worn out(chipped and rough) wheels and Resident #837 walker brake was not functioning (left brake not holding in place)and was missing a bolt from left folding arm of lower frame.

Interview of Staff #140 indicated that repair issues of wheelchairs and walkers are referred to physiotherapy staff.
Interview of PTA staff #138 indicated when physiotherapy staff are notified of required repairs of wheelchairs and walkers, the repair requests are recorded in the Shoppers Home Health Repairs binder log and the technician from Shoppers comes every Wednesday to complete and sign off when repairs are completed.

Review of the Shoppers Home Health repair log for the two month period had no documented evidence of repair logs for Resident #791 and Resident #802's wheelchair, or Resident #837's walker. [s. 15. (2) (c)]

4. The following areas were identified during the 4 day observation period:
a)Walls:
-resident rooms or washrooms #207, 209, 216, 223, 228, 333, 424, 502, 505, 506, and 518 were observed scuffed, having visible dry wall plaster or minor damage
- Kawartha and Trent unit spa rooms were missing wall tiles
b)Door Frames/Doors:
- resident rooms and washrooms #209, 216, 223, 228, 306, 309, 336, 404, 406, 409, 436, 438, 502, 506, 518 and Kawartha and Stoney spa rooms were observed with scuffed, paint chipped and or having damage visible to the wooden frames.
c)Equipment:
- Room #302 and 409 – the one side of a towel bar in a shared washroom was observed loose and detached from the wall
- Room #332 - the left arm of the toileting rails was observed to be duct taped; the

tape was tattered and visibly soiled
- Room #205 and #401 – the side rails of the bed, were observed to have paint chipping along entire length of the rail facing the door

An interview with the Administrator, Maintenance Manager and Housekeeping Manager indicated that the home had a maintenance program in place to address repairs within the home and that staff place concerns into the Maintenance Log Repair binder, which is checked on a regular basis by the Maintenance Manager.

A review of the maintenance repair log binder for Kawartha/Stoney/Trent Unit for the period of March 1, 2014 through to June 20, 2014, did not identify any of the above areas. [s. 15. (2) (c)]

WN #7: 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 :

The licensee failed to ensure that each resident of the home has his or her personal items, including personal aids labelled.

The following resident personal items were observed not labelled during the week of June 17 to June 20, 2014 in shared resident washroom counters:
-Room #301 – a green toothbrush
-Room #302 – a green toothbrush
-Room #332 – a brown brush
-Room #333 – a blue and white toothbrush, and a blue comb
-Room #401 – a burgundy toothbrush and an upper denture (lying in the sink)
-Room #409 – a green toothbrush and a brown brush
-Room #502 – bar soap in a white container

Interview of Staff #112 indicated that resident personal care items are to be labelled. [s. 37. (1) (a)]

2. The licensee failed to ensure the resident had their glasses cleaned as required.

Observation of Resident #869 on a specified date by Inspector #111 indicated the resident was observed lying in bed wearing heavily smudged glasses making them difficult to see out of.

Review of the care plan for Resident #869 indicated the resident required total assistance x1 staff for personal hygiene/grooming.

Review of progress notes of Resident #869 had no indication the resident refused grooming care on that specified date. [s. 37. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

The licensee failed to ensure that the resident was dressed in their own clean clothing

and wearing appropriate clean footwear.

Observation of Resident #802 on a specified date indicated the resident had soiled clothing. On another date the resident was again observed wearing soiled clothing. Two days later, the resident was again observed wearing the same soiled clothing. [s. 40.]

2. Observation of Resident #869 on a specified date, by Inspector #553 indicated the resident was wearing heavily soiled clothing. Two days later, Inspector #554 observed the resident wearing the same outfit as initially identified with the same heavily soiled clothing.

Interview by inspector #553 of Staff #101 (during that time period) when asked why the resident was wearing the same soiled clothing, stated the resident "is resistive to care".

Review of progress notes of Resident #869 during that 3 day observation period indicated:
-on day one (in the morning),the resident "was non-complaint" for care and staff approached several times and unsuccessful in attempts to provide care.
-on day 3 (during the night), the resident was "Non compliant for any personal care" and "Remains in clothing from evenings". "All interventions not effective".

Review of the care plan for Resident #869 indicated:
-dressing: extensive assistance x 1 staff with dressing process.
-behaviour(resists care/bathing): can become agitated, angry, aggressive (will strike out at staff, kick, and pull back when staff approach to provide care). Interventions included: If resident starts to swear, stop and explain again and ensure resident is ok to proceed; otherwise , stop and re-approach later; staff may have to take several turns in order to complete tasks;when resident refuses/resists care, distract or redirect by holding hand and speaking calmly, PRN medication to be given prior to providing care to aid in reducing aggressive behaviour; and provide flexibility in routine to accommodate mood.

There was no documented evidence that the resident refused care on two days of the observation period and no indication that when the resident refused care on day one, the resident was re-approached at a later time in the day for dressing/grooming, no indication the resident was offered medication as ordered, or that the resident

remained in the same soiled clothing for 3 days. [s. 40.]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

The licensee failed to ensure measures were in place to prevent the transmission of infections.

The following was observed:
-Room #409 had a soiled incontinence device observed for two days hanging on a towel bar next to a clean towel in a shared washroom.
-Room #502 had a soiled incontinence device observed on one day hanging on a towel bar next to a clean towel, in a shared washroom.

Staff #128, indicated that the PSW's are to rinse the incontinence device and hang over the towel bar in the resident's washroom, during the daytime. [s. 86. (2) (b)]

2. On two specified dates, it was observed in the soiled utility rooms in Trent unit(room #410) and in Stoney unit(room #210)with portable oxygen cylinders and oxygen compressors stored in one corner of the soiled utility room (in an area marked with yellow tape on the floor).These marked areas are located beside a hopper sink. On June 23, 2014, the soiled utility room on Stoney unit had an unflushed hopper and beside this hopper was a portable oxygen cylinder on wheels with nasal prongs attached. There were also five other portable oxygen cylinders also stored near the hopper sink.

On June 25, 2014 the soiled utility room in Otonabee Unit(Room #530) had three portable oxygen cylinders and a compressor stored there. One portable oxygen cylinder was labelled for Resident #795. These portable oxygen cylinders and compressor were stored in one corner of the soiled utility room marked with yellow tape on the floor beside a hopper sink.

Interview of Staff #140 and Staff #134 indicated that the hoppers in the soiled utility rooms are used to clean soiled resident clothing. Interview of the DOC indicated that oxygen cylinders are stored in soiled utility rooms but kept "in a marked area".

Storage of portable oxygen cylinders and/or tubing for individual resident use which are placed beside hoppers used for cleaning soiled clothing poses a cross contamination risk from splashing. [s. 86. (2) (b)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee failed to ensure that as part of housekeeping under clause 15(1)(a) of the Act, the licensee shall ensure that procedures are developed and implemented for, (d) addressing incidents of lingering offensive odours.

The following were observed during the dates of June 23& 24, 2014:
-a urine-like odour was noticeable, when entering two resident rooms.

Staff #122 indicated that odours in resident rooms are investigated, a through clean completed and then the housekeeping department would use special odour absorbing sponges to decrease the odours. Staff member #122 was not aware of the odours in Rooms #431 or #409. [s. 87. (2) (d)]

Issued on this 28th day of July, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), KELLY BURNS (554), MARIA FRANCIS-ALLEN (552), SAMI JAROUR (570)
Inspection No. / No de l'inspection :	2014_360111_0017
Log No. / Registre no:	O-000526-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 24, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE LAKEFIELD 19 FRASER STREET, P. O. BOX 910, LAKEFIELD, ON, K0L-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Dawn Baldwin

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Order / Ordre :

1)The licensee shall ensure that all direct care staff are informed prior to providing care, to any resident currently receiving end of life care/palliation. This to be complied with immediately.

2)The licensee shall ensure that all direct care staff are retrained on the homes policy of "Palliative Care and Death" to ensure that staff are aware of residents care needs (specifically repositioning and bed mobility) when on palliative care according to their written planned care (as per the compliance date).

Grounds / Motifs :

1. The licensee failed to ensure that the resident requiring end-of-life care received care in a manner that met the resident's needs, specifically to remain in bed with repositioning.

Review of the progress notes for Resident#835 indicated the resident had deteriorated and was deemed Palliative on a specified date.

Review of the care plan for Resident #835 indicated "palliative measures" and the resident was dependent on staff for all aspects of care, and the resident was to be turned every two hours in bed.

Observation of Resident #835 noted:
- 7 days before death during an 8 hour time period, the resident remained lying on their back with no evidence of repositioning.
- 5 days before death, the resident was found sitting in a wheel chair, fully clothed in day clothing, and sitting in the dining room with a plate of food in front of the resident while the resident remained unresponsive. A staff member attempted to feed the resident breakfast and was heard stating "I guess tired today".

Staff Interviews indicated the following:
- Staff #112 indicated the resident was not turned while in bed on the specified date because the resident "was on a special mattress".
- Staff #133 indicated the resident was assisted out of bed, dressed and taken to breakfast on a specified date as the staff member was not aware the resident was palliative and was directed by Staff #118 to take the resident to the dining room for breakfast.
- Staff #118 indicated direction was given to Staff #133 to take the resident to the dining room as resident was already out of bed and was not aware of the resident's change in health status. The resident was then returned to bed. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 29, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa Service Area Office