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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 24, 2015	2015_287548_0024	O-002823-15	Complaint

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 LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

RUZICA SUBOTIC-HOWELL (548)

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): October 9 and 13, 2015.

During the course of the inspection: home policies and protocols were reviewed and a resident health care record was reviewed and observed staff to resident interaction.

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

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Nutrition and Hydration
Skin and Wound Care

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. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented related to the skin and wound program, specifically, as it relates to O.Reg 79/10 s. 48 (1) (2) where the licensee failed to ensure 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 are documented.

Resident #001 was admitted to the home on specified day in August, 2013 and required assistance in Activities of daily living. On a specified day on September, 2013 the Enterostomal Therapist (ET) documented an assessment indicating the resident presented with coccyx Stage 2 pressure ulcer.

The following home policies were provided to the inspector by the DOC who confirmed the below process. The home's policy titled: Prevention of Skin Care, Policy number:03-03, dated June 2010 indicated that the care plan should outline any specific preventative skin care the resident requires based on the resident status and outcome of resident assessments. In addition, Weekly Skin Observation forms are to be used to record weekly skin observations with a bath or shower. The home's policy titled: Skin Care, Policy number:03-01, dated June 2010 indicated that the care plan is used to document all care needs and interventions related to skin, including active treatment as well as, preventative skin care interventions.

On October 9, 2015 the resident's #001 care plan was provided to the inspector #548 by the DOC. A review of the resident's #001 health care record was completed. There was no documentation of interventions in the care plan related to skin. In addition, there are two Weekly Skin/Month Observation forms, one dated for August 2013 and the other for September 2013. The August 2013 form is blank.

The licensee failed to ensure that the skin and wound program was complied with for resident #001. [s. 30. (2)]

WN #2: 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 failed to ensure a system to monitor and evaluate the food and fluid intake of a resident with identified risk related to nutrition and hydration.

Resident #001 required assistance with the activities of daily living and was admitted to the home on a specified day in August, 2013. The dietitian on admission documented resident #001 assigned a high nutritional risk. The dietitian further indicated resident #001 required a minimum millilitres of fluid per day and assistance with meals. The 24 hour care plan assessment dated for a specified day in August, 2013 indicated the resident #001 required a specified diet.

The home's process to monitor and evaluate resident intake includes the documentation of resident intake of both food and fluid per meal and nourishment, on a daily basis. On October 13, 2015 during an interview PSW #101 indicated the amount of intake for both fluids and food are documented on the Resident Daily Food and Fluid Intake form. RPN #102 confirmed that registered nursing staff review this form on a daily basis, monitoring resident intake. As well, RPN #102 indicated those residents diagnosed with specific pathology are monitored for the specified amount of fluid intake expected per day. RPN

#102 and PSW #101 both indicated that when a resident's intake is poor the PSWs are expected to communicate this to the registered nursing staff (for that particular meal and day). During an interview, the dietitian #105 indicated the same and further explained that registered nursing staff are to review the intake forms and when a resident's intake is not sufficient, less than 50 percent for each meal for three days, she is to be consulted.

On October 9, 2015 a hard copy of the resident's health record was provided to the inspector #548 by the DOC. The health care record was reviewed.

From the health care record review it is noted there are two Resident Daily Food and Fluid Intake forms. The form dated August, 2013 has two dates recorded with no record of food and fluid intake during that time. In addition, there were no registered nursing staff initials on the required form.

Progress note entry and Medication Administration Record (MAR) dated for the month of August, 2013 indicated the Food Intake Study concluded the resident's #001 oral intake was fair and the resident required cueing and encouragement to eat and finish meals. Review of the PSWs Daily Care Flow Sheets indicated this was provided.

Upon health care record review there is no Resident Daily Food and Fluid Intake form for a specified period of time in August, 2013 and was not produced at the time of the inspection.

Review of the progress notes from a specified period of time in August, 2013 was completed. A progress note entry dated for a specified day in August, 2013 indicated the resident did not eat breakfast and was not hungry. Review of the Resident Daily Food and Fluid Intake form indicated the resident #001 had a full breakfast and 2 -250 millilitres of fluids. Entries for several days following record intake as: ate well, ate full lunch meal, ate full supper. On a specified day in August, 2013 a progress note entry indicated the resident did not eat well. Subsequently, on days following it the resident's intake is recorded as :did not eat much, had a good meal at supper and ate a sandwich in its entirety.

On a specified day in August, 2015 a progress note entry reads: resident woke up feeling lethargic. POA informed and resident was brought to hospital with family concerns of low mood and weight loss. The resident #001 returned to the home the same day.

The Resident Daily Food and Fluid Intake form dated September 2013 was reviewed. It is noted there is some record of the resident's #001 intake during a specified period during the month. There are lapses in the documentation such as: no record of fluid or food intake for several days. In addition, it is recorded that the resident's #001 average intake was at 25 percent for certain meals and the resident refused the majority of nourishments at certain time of the day. It is noted registered nursing staff did not initial on the required form.

Review of the progress notes for September, 2013 was completed. There is no documentation regarding the resident's intake for specified days. Following these dates the resident presented with increased weakness and poor appetite. It is recorded that the POA was made aware.

On a specified day in September, 2013 the resident #001 is seen by the dietitian was placed on a Food Intake Study the same day for poor oral intake of foods and a trial of change in diet. On October 13, 2015 during an interview the dietitian indicated that she was aware the resident was consuming 25-50 percent of meals provided and supplements were ordered. Review of the medication administration record confirms the record of supplement administration.

The following day it is recorded in the progress note entry the resident #001 refused breakfast however, at a portion of the supper meal. Two days later the resident's intake for breakfast and lunch is recorded as barely eating.

On a specified day in September, 2013 a progress note entry indicated that the resident is not eating and exhibited lethargy. The POA is informed and requests the resident #001 stay at the home. Later that day the resident is transferred to hospital.

Shortly, thereafter the resident #001 passed away in hospital.

On October 13, 2015 during an interview the DOC confirmed the expectation for registered nursing staff is to review the Resident Daily Food and Fluid Intake form on a daily basis as an aspect of monitoring resident #001 daily intake. Furthermore, registered nursing staff are to initial the form to indicate the review is completed.

On October 13, 2015 a copy of the resident's care plan provided by the DOC was revised on the date of the resident's #001 death. It is noted from the review that the revised care plan specified the resident's nutritional and fluid needs and provided direction for staff

should the resident #001 intake be poor.

The licensee failed to ensure the home’s system to monitor and evaluate the food and fluid intake- documentation, review and consultation for a resident#001 who was assigned high nutritional risk with underlying pathology. [s. 68. (2) (d)]

Issued on this 15th day of January, 2016

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

Original report signed by the inspector.