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 8, 2016	2016_293554_0016	009951-16, 016805-16, 018494-16, 022070-16	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 PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

KELLY BURNS (554)

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): July 19-22, 2016

The following intakes were reviewed and inspected upon: #009951-16, 016805-16, 018494-16, and 022070-16.

Summary of Intakes:
1) #009951-16 - specific to staffing shortage and resident bathing not being completed;
2) #016805-16 - specific to substitute decision maker not being notified of changes in resident #001's health status and condition;
3) #018494-16 - specific to allegation of staff bringing in illegal substances and such is said to be affecting resident care and services;
4) #022070-16 - specific to staffing shortages, and resident bathing not being completed as a result.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (Clinical Coordinator), Office Manager, Nursing Clerk, Nutritional Care Manager, Environmental Services Manager, Best Practice Coordinator-Staff Educator, RAI-Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Medical Advisor, Regional Director for Extendicare, Peterborough Police Services and residents.

During the course of the inspection, the inspector, toured the home, reviewed clinical health records, and other documents, specifically, bath shift report sheets, rotational day notes reports, bath schedules, annual Sufficient Staffing Quality Protocol, and home specific policies including, Bathing, and Standards of Employee Conduct.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Reporting and Complaints
Sufficient Staffing

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure the substitute decision maker (Family #002) has been provided the opportunity to participate fully in the development and implementation of the plan of care, of resident #001.

Related to Intake #016805-16, for Resident #001:

Resident #001 was said to regularly attend scheduled medical appointments three times weekly.

According to the clinical health record, Family #002 is the substitute decision maker for resident #001; this was confirmed to be accurate as per the Clinical Care Coordinator, currently the Acting Director of Care.

The clinical health record, for resident #001, was reviewed for the period of approximately one and a half months. The following was documented:
- On an identified date – Resident noticed to be very warm to the touch, and had a temperature 38.6 degrees. Medication was administered.
- On an identified date (next day) – Seen by Nurse Practitioner (NP). Resident complaining of specified symptoms. Temperature remains elevated. NP identified resident to have a specific infection. Staff advised to monitor resident closely. Family #002 notified.
- On an identified date (next day) – Long-term care home notified a specific unit at an acute care site, that resident #001 has declined scheduled appointment today. Resident #001 stated to registered nurse, that he/she is "done in" and does not want to go.
- On an identified date (next day) – Resident remains in isolation. Continues to have symptoms.

- On an identified date (next day) – Continues with symptoms. Appetite not good today.
- On an identified date (next day), the following entries were documented:
- Resident did not attend scheduled appointment today, stating he/she did not feel well. Continues to symptoms, oxygen saturation low. Family #002 updated at an identified time.
- Approximately four-five hours later, registered nurse spoke again to Family #002. Family #002 indicated attempting to speak with resident #001 by telephone, family indicated difficulty understanding resident and remarked to registered nurse "that resident may be confused". Family #002 indicated that he/she "wanted to be called if resident takes a turn for the worst."
- Later that same shift, resident #001 was assessed by registered nurse, and found to have edema to specific areas.
- At an identified time, resident #001 said to have refused all shift medications, was assessed by registered nurse and found to be having difficulty swallowing.
- Approximately three hours later, resident's oxygen saturation declined further. Writer called physician for orders; an identified treatment was started. Resident continues to be symptomatic and appetite remains poor. Continues to respond when spoke too. Continues to be monitored.
- On an identified date (next day) – Family #002 notified at a specified time that resident #001 was deceased.

Family #002 indicated, to the inspector, that he/she had not been informed, by registered nursing staff, how unwell resident #001 was, had not been advised of resident not attending scheduled medical appointments until after the fact and had not been told resident #001 had tested positive for an identified illness. Family #001 indicated "the nurse was told to call me if resident #001's condition changed, and no one called me".

Following a review of the clinical health record and interviews with registered nursing staff and the Clinical Coordinator, now the Acting Director of Care, there is no evidence to suggest that Family #002, was advised of, resident #001 becoming ill on an indicated date; the first notification was approximately twenty-four hours later. Family #002 was not notified of resident #001 missing a scheduled medical appointment on an identified date; first notification of the missed appointment was made to the family three days later and following a second missed appointment. Was not notified that resident #001 tested positive for an identified illness. The family of resident #001 was not notified of resident's change in condition after a indicated time on an identified date and or before an indicated time on a said date.

As per the Acting Director of Care, the substitute decision maker and or the designate of the resident are to be notified of changes in a resident's condition. Acting Director of Care acknowledged that according to the clinical health record, Family #002 was not advised of resident #001's change in condition and or missing scheduled appointments. [s. 6. (5)]

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 there is a process in place and monitored, ensuring the substitute decision maker is provided the opportunity to participate fully in the development and implementation of the plan of care, specifically when a resident's health condition changes to a serious illness, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

Related to Intake # 009951-16 and #022070-16:

Personal Support Workers, Registered Nursing Staff, the Nursing Clerk, Clinical Coordinator and the Administrator, all remarked that the home is frequently short staffed. Nursing Staff, the RAI-C and the Clinical Coordinator, all indicated "short staffing is affecting resident care and services, specifically twice weekly bathing".

The Nursing Clerk indicated "when the home is short staffed, personal support workers complete a Bath Shift Report sheet to identify which residents have not received a bath on the identified shift; the Bath Shift Report sheet is signed by the registered nursing staff for the home area and then the Bath Shift Report sheet is forwarded to Nursing Clerk." Once received by the Nursing Clerk, the Bath Shift Report sheet is given to the Director of Care for review and direction.

Nursing Clerk indicated "in the past, the Director of Care would direct me to book a personal support worker to get missed baths caught up;" Nursing Clerk indicated "I have not been directed to bring in additional nursing staff to catch up missed baths for approximately seven months".

The Nursing Clerk provided the Bath Shift Report sheets (as well as rotation day notes reports, a staffing variance report) for a four month period; these records were reviewed, by the inspector, and identified dates in which the long-term care home was short staffed and further identify dates in which resident care, specifically bathing was not completed. Nursing Staff have indicated reasons for not completing resident bathing, to include, "time constraints" and "short staffed".

The Nursing Clerk and the Clinical Coordinator both indicated residents missing baths are not being offered alternative dates or times for bathing, as their was no plan in place to get missed baths caught up.

The Administrator provided the inspector with a document identified as "Plan B for Staff Shortages", which is dated January 2012.

The document titled "Plan B for Staff Shortages" directs the following:
- During the day and evening shift, registered (nursing) staff will pull the spa shift when the unit is short one personal support worker, and all staff will then perform resident assigned baths/showers.
- Notify the Nursing Clerk, who will attempt to schedule extra shifts for spa shift, if baths were not completed.

Personal Support Worker (PSW) #055, Registered Nurse (RN) #053, who was the Charge Nurse, and the Nursing Clerk all indicated that the long-term care home did not have a back-up plan in place to direct staff what to do if resident home areas are short staffed.

The Clinical Coordinator, currently the Acting Director of Care indicated the "back up staffing plan provided by the Administrator, was not current". The Acting Director of Care indicated "the long-term care home has not had a spa shift in a least a year or longer."

The Acting Director of Care indicated "the long-term care home currently has no back-up staffing plan" that addresses situations when staff cannot come to work. [s. 31. (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 the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Related to Intake # 009951-16 and #022070-16:

Resident #003 is dependent on staff for activities of daily living; resident is cognitively well. Resident #003 indicated, to the inspector, that he/she is scheduled to have his/her showers on two specific dates during the week. Resident #003 indicated he/she is not consistently provided him/her twice weekly bathing. Resident #003 indicated he/she "seldom receives a shower on an identified day, due to the home being frequently short staffed." Resident #003 commented that he/she "has only had one shower weekly for the past three weeks."

Point of Care (home's electronic resident flow sheets, care documentation) was reviewed for a period of approximately one month, and such documents that resident #003 did not received twice weekly bathing during this said period.

The RAI-Coordinator (RAI-C), who oversees the bathing schedules for the long-term care home, confirmed that resident #003 is scheduled to have showers twice weekly. RAI-C reviewed the Point of Care (POC) documentation, specific to bathing for resident #003, and confirmed that resident #003 had not received twice weekly showers as per the bathing schedule. RAI-C indicated "during the identified month, resident #003 had not had his/her scheduled twice weekly showers." RAI-C indicated "resident #003 had only one shower provided to him/her during the past three weeks."

2. RAI-Coordinator (RAI-C), as well as the Clinical Coordinator, now Acting Director of Care, both indicated each resident is scheduled to receive twice weekly bathing unless otherwise noted in the resident's individualized plan of care.

The RAI-C provided, the inspector with, the Point of Care (POC) records, specific to bathing, for all resident home areas, for the period of approximately one month. RAI-C indicated documentation charted, by personal support workers, in the POC as "not applicable" indicates that a bath, shower or bed bath was not performed on the indicated date.

A random review of the POC documentation was reviewed, by the inspector, for the period of approximately three weeks, documents that twice weekly bathing had not occurred for approximate twelve identified residents.

Point of Care documentation, as well as Bath Shift Report sheets were reviewed, by the inspector, for a further time period, which included a three month period. This record review provided additional support that residents are not being bathed, at a minimum, of twice a week by the method of his or her choice.

Personal Support Worker (PSW) #055, Registered Nurse #053 and #054, Nursing Clerk, and the RAI-C, all indicated that residents are not receiving twice weekly bathing, due to staffing issues and workload. PSW #055 and Registered Nursing Staff indicated resident's were not offered alternative dates for bathing, if baths or showers were not completed staff would enter "not applicable" into POC.

The Nursing Clerk indicated "the Director of Care reviewed bath shift report sheets, on a regular basis, noting times when the home was short staffed and resident care was not completed;" Nursing Clerk indicated that "the DOC was aware that bathing was not consistently being provided to all residents as per the bathing schedule".

The RAI-C, who reviewed the POC documentation with the inspector, indicated "according to the POC documentation, no alternative bathing dates were offered to residents noted as not receiving scheduled bath or shower and there is no indication that a alternative bathing method (e.g. bed bath) was offered to resident those same residents."

The Director of Care (DOC) was not available for interview during this inspection; Administrator indicated DOC is not longer employed at the long-term care home.

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 there is a process in place and monitored, ensuring residents are bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.