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 sions 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
Apr 18, 2016	2016_353589_0006	001743-16	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 ROUGE VALLEY
551 Conlins Road TORONTO ON M1B 5S1

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

JOANNE ZAHUR (589), JULIENNE NGONLOGA (502)

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 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, March 1, 2, 3, 4, 8, 8, and 9, 2016.

This complaint log #001743-16 was inspected concurrently with the resident quality inspection (RQI) #2016_353589_0005.
Findings of non-compliance related to s. 6.(10)(b) will be issued in RQI report #2016_353589_0005.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC, Assistant Director of Care (ADOC), Registered Nurse(RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Registered Dietitian (RD), and Physician.

During the course of the inspection, the inspector(s) conducted a tour of the home, staff and resident interactions and the provision of care, record review of health records, staff training records, care conference schedule and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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 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 :

1. The licensee has failed to ensure that any policy put in place is complied with.

Review of the home policy titled "Food and Fluid Intake Monitoring" #RESI-05-02-05, revised in September 2014, revealed registered nursing staff should send a referral to the RD if a resident consumed 50 per cent or less from all meals for three consecutive days and notify the physician of the resident's nutritional status.

Review of resident #012's total fluids and food intake reports from identified dates in November 2015, to January 2016, revealed that starting on an identified date in December 2015, the resident's food intake decreased from 75 per cent or more to less than 25 per cent food intake for all meals per day.

Interview with RPN #131, RD #155, and DOC #105 confirmed the above mentioned change in resident nutritional status and indicated that a referral was sent to the RD on an identified date in January 2016, seven days after initial observations of the change in resident's nutritional status. [s. 8. (1) (a),s. 8. (1) (b)]

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 any policy put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission.

Interview with the Executive Director (ED) revealed that the previous SW had left on an identified date in November 2015, resulting in the absence of a SW in the home for five weeks. The ED revealed the duties of the SW included liasion with Behavioural Support Ontario (BSO), Geratric Management Outreach Team (GMOT), Community Care Access Centres (CCAC), reviewing CCAC applications, admissions/discharges, booking of care conferences, both annual and new admission. During this time the director of care (DOC) had assumed the responsibility of the SW however admission care conferences had not been booked.

Record review of resident #004's most recent written plan of care revealed an interdisciplinary care conference was held on an identified date in January 2016, seven weeks after his/her admission date on an identified date in November 2015.

Further record review revealed the following resident's admission care conferences had not been booked within six weeks of admission:
-resident #021, was not held until 13 weeks after admission,
-resident #022, was not held until eight weeks after admission,
-resident #023, was not held until 10 weeks after admission,
-resident #024, was not held until 13 weeks after admission,
-resident #025, was not held until 11 weeks after admission and,
-resident #026, was not held until 10 weeks after admission.

Interview with the ED confirmed that the home had failed to ensure that a care conference of the interdisciplinary team for resident #004 was held within six weeks of their admission to the home. [s. 27. (1) (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 a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission, 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 :

1. The licensee failed to ensure that when resident #004 was demonstrating responsive behaviours actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that resident #004's responses to interventions were documented.

Resident #004 was admitted on an identified date in November 2015, with multiple underlying health conditions.

Record review of a behavioural assessment tool completed by the community care access centre (CCAC) dated on an identified date in August 2015, revealed resident #004 demonstrated responsive behaviours.

Record review of the progress notes for resident #004 revealed multiple incidents of responsive behaviors demonstrated between November 2015 and January 2016.

Record review of the dementia observation system (DOS) tool revealed it had been initiated on an identified date in January 2016, and completed on an identified date in January 2016. There was no record of the DOS tool being analyzed to identify trends or patterns in resident #004's behaviours.

Interview with registered staff #131 revealed that since admission resident #004 had been demonstrating increasing behaviours and that the primary physician had been notified.

Interview with the primary physician revealed that on admission he/she had decreased an existing medication by an identified amount as was concerned the admitting dosage would have increased resident #004's risk for falls.

Record review of the written plan of care initiated on an identified date in December 2015, revealed under the behaviour focus that wandering and socially inappropriate behaviour had been addressed with corresponding interventions to redirect resident #004 into his/her room or to the lounge and staff to make sure he/she was appropriately dressed at all times. The other above mentioned behaviours that had been demonstrated since admission were not identified in the written plan of care.

Record review of a progress note on an identified date in December 2015, written by the primary physician revealed that resident #004 had not fallen, there were no behaviors demonstrated, and the resident was getting comfortable.

Interview with the primary physician confirmed that he/she had not been made aware of any increasing behaviours demonstrated by resident #004 and as a result current interventions had not been reassessed. [s. 53. (4) (c)]

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 that when a resident is demonstrating responsive behaviours actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the residents responses to interventions are documented, to be implemented voluntarily.

Issued on this 20th day of April, 2016

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

Original report signed by the inspector.