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

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

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 21, 2013	2013_205129_0008	H-000188-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE SOUTHWESTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE ST. CATHARINES
283 Pelham Road, St. Catharines, ON, L2S-1X7

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

---

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

This inspection was conducted on the following date(s): July 18, 22, 23,24 and 29, 2013

This complaint inspection was initiated in relation to a complaint received (Log # H-000188-13)relate to care concerns that including care related to falls, skin and wound care, medication administration and the management of other needs. demonstrated by the resident.

During the course of the inspection, the inspector(s) spoke with residents, resident's substitute decision makers, registered and unregulated nursing staff, the staff person responsible for the documentation of mandatory training, the Physiotherapist, Director of Care and the Administrator.

During the course of the inspection, the inspector(s) observed resident care, reviewed clinical record documents, reviewed staff training documentation and reviewed the home's policies (Falls, Skin and Wound and Anticoagulant Therapy)

The following Inspection Protocols were used during this inspection:
Falls Prevention

Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 :

1. The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in the plan, in relation to the following: [6(7)]
a) Care as specified in the plan of care was not provided to resident#001, when on three occasions the resident was noted to be positioned on the left side while in bed. Care directions located at the bedside and in the point of care system directed staff to turn and reposition the resident every two hours while in bed and avoid positioning the resident on the left side. The resident was noted to be positioned on the left side on July 23, 2013 at 1015hrs., on July 24, 2013 at 1115hrs. and on July 31, 2013 at 1105hrs. Personal support worker #107 confirmed that the directions for care were that the resident was not to be positioned on the left side. At the time of this inspection resident #001 was noted to have areas of skin breakdown.
b) Care as specified in the plan of care for resident #002 was not provided to the resident when the resident fell from the wheelchair and fell from bed. The plan of care for resident #002 directed that the resident was to have a rear fastening seatbelt applied when sitting in the wheelchair in order to manage an identified risk for falling and was also to have a floor mat positioned on the floor beside the bed in order to minimize the risk for injury from falling from bed. Staff and documentation in the clinical record confirmed that on an identified date the resident was found by staff to have fallen from the wheelchair and the rear fastening seatbelt had not been applied. Documentation also confirmed that on a second identified date staff responded to an alarm, found the resident had fallen from the bed to the floor and the floor mat was not in place. [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 and ensuring that the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 did not ensure that where the Act or this Regulations requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, strategy or system, that the plan, policy, protocol, strategy or system was complied with, in relation to the following: [8(1)(b)]

a) Staff in the home did not comply with the homes policy [Anticoagulant Therapy #11-10] dated September 2012 when care plans were not developed for resident #001 and resident #003 who were receiving anticoagulant therapy. The home's policy directs that staff will develop a care plan related to the potential side effects, risks and care requirements for a resident receiving anticoagulant therapy. Clinical documentation confirmed that resident #001 was ordered to receive anticoagulant therapy; however, there was not a care plan in place in accordance with the home's policy. Clinical documentation confirmed that resident #003 was receiving anticoagulant therapy; however, there was not a care plan related to the increased risk related to receiving anticoagulant therapy in accordance with the home's policy.

b) Staff in the home did not comply with the homes policy [Skin Care Program Overview # 03-01] dated June 2010 when quarterly assessments of skin were not completed for resident #003 and #004 who were identified as having skin breakdown. Registered staff #101 and #104 confirmed that only skin breakdown related to pressure ulcers are triggered through the Minimum Data Set/Resident Assessment Protocol system and that the home has a system of non-triggered assessment tools that staff are to use for quarterly review of skin breakdown that is not related to pressure. The two identified staff and clinical documentation confirmed that resident #003 experienced ongoing skin breakdown from falling and resident #004 experienced ongoing skin breakdown related to vascular issues; however, neither resident #003 or #004 had quarterly assessments of issues related to skin breakdown. [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 and ensuring wherever this Act or the Regulations require the licensee to have, institute or otherwise put in place any plan, policy, protocol, strategy or system that staff comply with those directions, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provide direct care to residents received, as a condition of continuing to have contact with residents, training in the area of skin and wound care on an annual basis, in accordance with O. Reg. 79/10, s. 221(1)2 and 21(2)1, in relation to the following: [76(7)(6)]
Documentation of training provided by the home at the time of this inspection confirmed that 66 of 130 staff who provide direct care to residents did not receive training in the area of skin and wound care in 2012. [s. 76. (7) 6.]

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 and ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the area of skin and wound care on an annual basis, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the requirement for staff to ensure that a physical device is applied in accordance with manufacturer's instructions was met with respect to restraining a resident, in relation to the following:[110(1)2]
Resident #002's plan of care indicated the resident was at risk for falling. To manage this risk a care intervention that included the application of a rear fastening seatbelt restraint while the resident was sitting in the wheelchair was put in place. On four occasions staff and clinical document confirmed that the seatbelt was not applied according to manufactures directions causing the resident to be at further risk for injury.
-On an identified date the seatbelt restraint had not been applied properly and registered staff documented in the clinical record that the resident slid from the wheelchair while outside in the garden. Staff documented that the seatbelt was loose and was noted to be under both arms.
-On a second identified date the seatbelt restraint had not been applied properly and registered staff documented in the clinical record the resident had slid down in the wheelchair and the seatbelt was noted to be under the resident's breasts.
-On a third identified date the seatbelt restraint had not been applied properly and registered staff documented in the clinical record the resident had slid down in the wheelchair, the seatbelt was loose and noted to be under the resident's breasts. Staff also noted there was redness under the resident's breasts caused by the seatbelt.
-On a fourth identified date the seatbelt restraint had not been applied properly and registered staff documented in the clinical record the resident was found sitting on the floor with the wheelchair at the resident's back and the seatbelt across the resident's chest. Staff noted that the resident had slid down from the wheelchair and on assessment the resident was noted to have redness across the back and chest area caused by the tightening of the seatbelt as the resident slid from the chair. [s. 110. (1) 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 and ensure that the requirement for staff to ensure that a physical device is applied in accordance with the manufacturer's instructions is met with respect to restraining a resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were stored in an area or a medication cart that was secured and locked, in relation to the following: [129(1)(a)ii]
The medications were unsecured on July 23, 2013 and July 24, 2013
On July 23, 2013 at 1215hrs. the medication room door was left open. Registered staff were found to be in the dining room which is located in a separate hallway to the area were the medication room is located. Staff appeared unaware that the medication room was left open. At this time one resident was noted to be walking through the home area around the nursing station and in the lounge that is located beside the nursing station.
On July 24, 2013 at 1200hrs the medication cart was noted to be unlocked in the hallway outside the nursing station. Nursing staff were noted to be in the nursing station area; however, because of the design of the area did not have visual contact with the unlocked medication cart. This inspector was able to walk up to medication cart, open drawer and could have easily removed medications. At this time many residents where noted to be in the hallway moving to the dining room for lunch. [s. 129. (1) (a) (ii)]

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 and ensuring that drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee did not ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber, in relation to the following: [131(2)]
Registered staff did not ensure resident #001 received medication as ordered by the resident's physician during the monitored period in June and July 2013.
Resident #001's physician ordered that the resident was to receive the following:
-A 10 mg tablet of an identified medication by mouth daily; however, clinical documentation indicated that the resident did not receive this medication 10 times over the 30 days in June 2013 and nine times over the first 23 days in July 2013.
-A 120mg capsule of an identified medication by mouth daily; however, clinical documentation indicated that the resident did not receive this medication 10 times over the 30 days in June 2013 and seven times over the first 23 days in July 2013.
-A 0.15mg tablet of an identified medication daily; however, clinical documentation indicated that the resident did not receive this medication nine times over the 30 days in June 2013 and eight times in the first 23 days in July 2013.
-A 40mg tablet of an identified medication by mouth daily in the morning; however, clinical documentation indicated that the resident did not receive this medication 10 times over the 30 days in June 2013 and eight times over the first 23 days in July 2013.
-One to two tablets of a 5mg identified medication by mouth at bedtime; however, clinical documentation indicated that the resident did not receive this medication once in June 2013 and 10 times in the first 23 days of July 2013.
-One and a half tablets of a 7.5 mg identified medication, by mouth in the evening; however, clinical documentation indicated the resident did not receive this medication 15 times over the 30 days in June 2013 and 10 times over the first 23 days of July 2013
-The contents of a 18mcg capsule of an identified medication, to be inhaled daily via hand held inhaler; however, clinical documentation indicated the resident did not receive this medication 10 times over the 30 days of June 2013 and nine times over the first 23 days in July 2013.
Staff documented on the Medication Administration Records for June and July 2013 that the reason the resident did not receive the above noted medications were either that they were refused by the resident or the resident was sleeping. Registered nurse #103 and Registered Practical Nurse #102 confirmed that no action was taken to alert the physician that the resident was not taking medications, no action was taken to consult with the pharmacist regarding the administration times of these medications and no actions were documented in the clinical record related to attempts address the

refusal behaviour being demonstrated by this resident. [s. 131. (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 and ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee did not ensure that there was monitoring and documentation of resident #001's response to and the effectiveness of medications ordered by the resident's physician, in relation to the following: [134(a)]
Resident #001 was ordered to receive a medication to manage identified needs related to sleep. Staff and clinical documentation confirmed that resident #001 demonstrated sleep/wake cycles disturbances; however, the resident's response to this drug and the effectiveness of this drug in stabilizing the residents sleep/wake cycle was not documented. At the time of this inspection the resident continued to experience sleep/wake cycle disruptions.
Resident #001 was also ordered to receive two medications in order to manage identified needs related to mood and behaviours. Staff and clinical documentation confirmed that the resident demonstrated agitation and resistance to care; however, the resident's response to these medications and the effects of these medications on managing the mood changes and the responsive behaviours were not documented. At the time of this inspection the resident continued to demonstrate agitation and resistive behaviours. [s. 134. (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 by ensuring that when a resident is taking a drug or a combination of drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drug appropriate to the risk level of the drug, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that the right of all residents to have their personal health information kept confidential in accordance the Personal Health Information Protection Act, 2004 was fully respected and promoted, in relation to the following: [3 (1)11iv]
On July 23, 2013 a journal containing notes registered staff use to make note about residents as well as several resident clinical records containing personal health information where note to be lying on an open counter at the nursing station. This counter is assessable to any person walking in the main hall of the second floor home area. At 1307hrs a resident was noted to walk by the counter and pick up the journal containing information about resident's medical appointments and health issues. A maintenance staff person was noted to question what the resident was looking at and then redirected the resident while putting the journal back on the nursing station desk. Registered staff were not in attendance at the nursing station during this incident and had not ensure that resident personal health information could not be viewed by other residents or visitors walking in the main hallway of this nursing home area. [s. 3. (1) 11. iv.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee did not ensure the Director was informed no later than one business day after the occurrence of an injury in respect of which a person is taken to hospital, in relation to the following: [107(3) 4]
Staff #105 confirmed that the home did not notify the Director and did not submit a critical incident report when resident #001 was sent to the hospital to assess injuries sustained as a result of a fall. Staff and clinical record documentation confirmed that resident #001 fell from the wheelchair on an identified date resulting in a head and arm injury. The following day staff noted the resident was complaining of hip pain and shoulder pain for which the resident was given a narcotic analgesic. In the early afternoon of this same day staff document that the resident continued to complain of hip pain and was therefore sent to the hospital for assessment.[s. 107. (3) 4.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply

Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

2. Access to these areas shall be restricted to,

i. persons who may dispense, prescribe or administer drugs in the home, and

ii. the Administrator.

3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee did not ensure that steps were taken to ensure the security of the drug supply, specifically access to the area where drugs were stored was not restricted to persons who may dispense, prescribe or administer drugs in the home, related to the following: [130(2)i]

At 1110hrs on July 29, 2013 the Registered Practical Nurse gave the medication room key to a courier from the pharmacy in order that this person could retrieve a storage container. The courier was noted to unlock the medication administration room, enter the room for a brief period of time and then left the medication room with a storage container. [s. 130. 2. i.]

Issued on this 22nd day of August, 2013

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

Phyllis Hiltz-Bontje