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
Nov 3, 2014	2014_257518_0039	L-001330-14	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 TECUMSEH
2475 ST. ALPHONSE STREET, TECUMSEH, ON, N8N-2X2

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

ALISON FALKINGHAM (518), ALICIA MARLATT (590), CAROLEE MILLINER (144)

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): September 29, 30, 2014 October 1, 2, 3, 6, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Maintenance Supervisor, the Programs Director, the Office Administrator, RAI Coordinators, Registered staff, Personal Support Workers, Dietary Manager, residents and resident family members.

During the course of the inspection, the inspector(s) observed general and specific resident care, a meal service, a medication pass, reviewed residents clinical records and the homes policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Sufficient Staffing

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 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 failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with the Act.

During the initial tour of the home on September 29, 2014 the PSW flow sheet binder was found open sitting on top of the soiled linen cart containing confidential resident flow sheets and information in the hallway of Lakewood House.

A Registered Practical Nurse confirmed the binder should not have been sitting on the soiled linen carts.

On September 30, 2014 the PSW binder was found again sitting on top of the soiled linen cart in the hallway of Lakewood House open containing confidential resident flow sheets and information.

A RAI Coordinator confirmed the binder should not have been sitting on the soiled linen carts.

The Director of Care confirmed it is the homes expectation that resident information is kept confidential at all times. [s. 3. (1) 11. iv.]

2. During the observation of medication administration on October 6, 2014 at 0800 it was noted that individual residents medication packages which had their names and room numbers as well as the medications included in the package were discarded in a garbage bag.

Further observation on October 6, 2014 at 1000 found that medication packages with resident identifying information were found in open accessible garbage on all four units of the home.

Interviews with 3 RPNs on 3 different units revealed that the routine practice is to open these medication packages when dispensing the medication to the resident and then place the packaging in the garbage bin on the side of the medication cart. When the garbage is full it is tied off and taken out to the external garbage bin by the housekeepers.
The identifying information is not altered in any way to hide the resident's personal health information prior to being discarded in the garbage bin.

The Director of Care confirms the expectation is to remove any resident specific identifying information prior to discarding the medication packaging. [s. 3. (1) 11. iv.]

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 every resident has the right to have his or her personal information kept confidential in accordance with the Act, to be implemented voluntarily.

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. (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 has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

Resident #0033's MDS data and Care Plan indicate that the resident is a two person transfer for safety and toileting purposes.
The inspector also observed a two person transfer logo in Resident #0033's room.
Of 3 interviews conducted with direct care staff 2 staff members indicated that Resident #0033 is a one person transfer and they have been using the one person transfer for this resident's care.

The Director of Care confirmed staff should follow the directions provided for in the care plan and further confirmed Resident #0033 should be reassessed to determine appropriate transfer safety. [s. 6. (7)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a PASD to assist a resident with a routine activity of living may be included in the resident's plan of care only if the PASD has been consented to by the resident or a substitute decision maker of the resident with the authority to give that consent.

Resident#0031 was observed in a tilt wheelchair in the reclined position on September 29, 2014 and October 2, 2014.

The Administrator and Director of Care confirmed the tilt wheelchair is a PASD and it is used by this resident to assist with a routine activity of daily living.

Personal Assistance Service Devices Policy RESI-10-01-06 last revised November 2012 indicates that informed consent must be obtained from the resident or POA.

Resident #00031 chart and plan of care was reviewed October 2, 2014 and no consent for the use of the PASD found.

The Director of Care confirmed this consent was not obtained.

The Director of Care confirmed it is the expectation that consent be obtained for the use of PASDs' prior to their application. [s. 33. (4)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's written record is kept up to date at all times.

Resident #016 experienced a fall [redacted]
On the date of the fall, a progress note and the post fall assessment in the resident's clinical record identifies the resident fell outdoors in the court yard.
On the date of the fall, a second progress note and the Risk Management Report in the resident's clinical record identifies the resident was found on the floor in their bedroom.
One nursing staff confirmed the discrepancies between the above entries in the resident clinical record.
[redacted] [s. 231. (b)]

Issued on this 3rd day of November, 2014

[redacted]

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