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
Sep 29, 2014	2014_281542_0019	S-000343-14	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 VAN DAELE
39 Van Daele Street, Sault Ste Marie, ON, P6B-4V3

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

JENNIFER LAURICELLA (542), DIANA STENLUND (163), MARINA MOFFATT (595)

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): August 25, 26, 27, 28, 29 and September 2, 3, 4, 5, 2014 .

Ministry of Health and Long-Term Care Critical Incident Log # S-000410-14 and Complaint Logs, S-000354-14 and S-000416-14 were inspected concurrent with the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Dietitian (RD), Program Manager, Support Services Manager, RAI Coordinator, Registered Staff, Personal Support Workers (PSWs), Maintenance and Housekeeping staff, Family Council Members, Resident Council Members, Families and Residents.

During the course of the inspection, the inspector(s) made direct observations of the delivery of care and services to residents, conducted a daily walk-through of the home, reviewed resident's health care records and various policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. During the initial tour of the home it was noted by the Inspectors that the floors in the shower rooms on the 2nd and 3rd floor appeared uneven, had water pooling in certain areas, water was not reaching the drainage system, blackened caulking/grout, and cracked shower walls. In the right shower room on 3rd floor, it was confirmed by the Director of Care that there was water pooling under the tub, uneven flooring and blackened caulking/grout.

On September 3, 2014 Inspectors #163 and #595 spoke with Personal Support Worker (PSW) # 100 who stated that the floor is warped in the shower room and can cause water to pool and can be difficult and dangerous to move residents around in the lift.

On September 4, 2014 Inspectors #163, #542 and #595 spoke to Maintenance staff # 101 who acknowledged that the floors in the shower rooms are warped and uneven, and is aware that staff have concerns regarding safety risk when transferring residents using mechanical lifts and water pooling.

The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. [s. 15. (2) (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 to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. Inspector # 163 and # 542 reviewed the health care records for residents # 04, 08 and 09. All three residents required the use of bed rails according to their care plans. The Inspectors were unable to locate any documentation to support that their bed systems were evaluated to minimize risk to them.
Inspector # 163 interviewed the Director of Care (DOC) and was informed that the home does not currently evaluate any of the bed systems for residents that use bed rails.

The licensee has failed to ensure that where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. [s. 15. (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 were bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. During the course of the inspection, Inspector # 163 observed PSW # 102 obtain a piece of paper towel and wipe urine off of resident # 09's bathroom floor. The PSW put the dirty paper towel in the trash, however failed to follow through with hand hygiene after disposing of the soiled paper towel. On September 3, 2014 Registered

Practical Nurse (RPN) # 104 was observed to administer insulin to a resident. This process required RPN # 104 to pull down the resident's underwear to inject the insulin into the lower abdomen. After the injection, the RPN proceeded to carry on other duties before cleaning their hands. On another occasion Inspector # 595 observed a resident # 13's oxygen tubing (nasal prongs) on the floor and a staff member picked them off of the floor and applied them to a resident's nares. On one of the floors, a resident was on contact isolation precautions and Inspector # 542 observed a stocked clean linen cart in the room, the cart is used to store clean linens for multiple other residents that are not on contact precautions. The Inspector also observed 2 urinals on the same table as where the resident's fluids and snacks were placed. The Inspector notified the Registered Nurse (RN) who verified that the clean linen cart and the urinals were put in the wrong place.

The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program. [s. 229. (4)]

2. On September 4th, 2014, Inspector # 542 reviewed the health care record for resident # 14. The Inspector was unable to locate any documentation as to whether resident # 14 was screened for tuberculosis (TB) within 14 days of admission. Inspector spoke with the Assistant Director of Care (ADOC) who verified that resident # 14's TB screening must have been missed.

The licensee has failed to ensure that each resident admitted to the home screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. [s. 229. (10) 1.]

3. On September 4th, 2014, Inspector # 542 reviewed the health care record for resident # 15 and was unable to locate any documentation as to whether the resident was offered the tetanus and diphtheria vaccine and the pneumoccocus. The ADOC verified that the immunizations must have been missed for resident # 15.

The licensee has failed to ensure that residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. [s. 229. (10) 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 that;
1) All staff participate in the implementation of the infection prevention and control program.
2) All residents are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
3) Residents are offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website, to be implemented voluntarily.

WN #4: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).

19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. On September 3, 2014 RPN # 104 was observed by Inspector # 595 to put resident # 16's empty medication package in the garbage on the medication cart. The medication package included the resident's name, room number and the name of the medications.

Inspector # 595 asked RPN # 104 what the home's policy was for disposing of the packages. RPN # 104 stated that they put them face down in the garbage and then at the end of their med pass/shift they take the medication cart garbage to the main garbage in soiled utility.

Inspector #595 found an empty medication package for resident # 17 on the floor of 3rd floor common area where numerous residents were sitting. Inspector brought this to the attention of Director of Care (DOC). Inspector asked the DOC about the home's policy for the medication packages who confirmed that the home throws the resident medication packages in the regular garbage. The home does not destroy the resident information in any way.

The licensee failed to ensure that residents' personal health information is kept confidential. [s. 3. (1)]

WN #5: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. A Critical Incident Report and a Complaint Letter regarding resident # 08 were reviewed during the RQI.
On August 27th, 2014 Inspector # 542 conducted a health record review for resident # 08. Resident had a recent hospital admission as the resident sustained injuries due to a fall. Resident # 08 returned from the hospital with a significant change of health status requiring a substantial increase of assistance from the staff to perform Activities of Daily Living. The home did not review and revise the resident's plan of care until 4 days after the resident's return from the hospital. On August 28th, the Inspector spoke with the Assistant Director of Care (ADOC) and the Administrator, both of which verified that the plan of care was not reviewed and revised until 4 days after the resident returned from the hospital and that it was updated too late.
The licensee has failed to ensure that resident # 08 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary. [s. 6. (10) (b)]

WN #6: 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. A Critical Incident Report and a Complaint Letter regarding resident # 08 were reviewed during the RQI.
On August 28, 2014 Inspector # 542 completed a health record review for resident # 08. The health records indicated that the resident had a fall and was found to have a contusion, a bloody nose and the fall was unwitnessed. The record review indicated that the resident was transferred off of the floor using a mechanical lift and was placed in bed to wait for the ambulance. The Inspector interviewed several different Registered Staff and was informed that if a resident has fallen and there is an injury or a suspected injury then they do not move the resident, an ambulance is called immediately. The Administrator provided a policy titled "Emergency Situations" to the Inspector in which she verified that the policy states if a resident has bleeding from their nose, ears or mouth it may indicate a fracture of the skull, do not move the resident, call ambulance immediately.
The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. [s. 8. (1) (a),s. 8. (1) (b)]

WN #7: 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. A Critical Incident Report and a Complaint Letter regarding resident # 08 were reviewed during the RQI.
Inspector # 542 conducted a health record review with regards to resident # 08. Resident # 08 had a fall which resulted in several fractures. Upon review of the documentation the Inspector was unable to locate specifics related to the fall in the progress notes or on the post falls assessment record. On August 28th, 2014 the Inspector interviewed Registered Nurse # 108 that conducted the assessment on the resident the day of the fall and was informed that they had difficulties with Point Click Care that day. The Registered Nurse then completed the documentation 4 days after the fall. On September 3, 2014 the Inspector interviewed the Administrator who verified that the assessment, interventions and resident's responses to interventions were not initially documented and that Registered Staff # 108 will be receiving disciplinary action due to the lack of documentation.

The licensee has 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. [s. 30. (2)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. On August 29, 2014 Inspector #595 observed Personal Support Worker (PSW) # 105 transferring resident # 03 using a sit-to-stand lift on their own. Inspector asked the PSW what the home's policy was for using mechanical transferring devices. The PSW informed the Inspector that 2 staff are to transfer a resident however they could not find anyone to assist them. Inspector asked if there was another staff member in the bathroom and PSW # 105 stated that there was no one else. Inspector informed Registered Nurse of the improper transfer. The Registered Nurse said that "this is an ongoing problem."
Inspector spoke with the Administrator who informed Inspector that the Registered Nurse had already informed her of the improper transfer. During the interview with the Administrator they indicated that the home's policy outlines the use of two staff when using a mechanical lift.

Inspector #595 reviewed the home's policies 'Safe Resident Handling Procedure: Sit to Stand Mechanical Lift' and 'Safe Lifting with Care Program' 01-02. The policies indicates that two trained staff are required at all times when performing a mechanical lift.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents. [s. 36.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. On August 27, 2014 Inspector #163 and #595 interviewed the Support Services Manager. It was noted that resident bathrooms were cleaned once per day. Deep cleaning of the bathrooms were completed on a rotation between shifts and staff members. Inspectors asked about the home's process for resolving lingering odours. The Support Service Manager stated that housekeeping staff would bring the information forward. They also stated that an audit tool could be used but the home would assess the situation instead. The home would identify the cause of the odour, if the resident has any behaviours, whether there is a care issue, or if it is a housekeeping issue. The housekeeping staff and the health care staff would work together to determine cause. The Support Services Manager stated that the housekeepers could place a deodorizer in the bathroom if it can’t be resolved, or use citrus charcoal however masking the odour is not a first choice. If the resident is having difficulty using toilet, the housekeepers would be notified about providing increased cleaning to that bathroom. Both the Support Services Manager and the Administrator acknowledged that toileting behaviours need to be further looked into should lingering odours be present.

Between the dates of August 26 and September 3, 2014 Inspector #163 and #595 checked resident # 09's bathroom and it was noted on multiple occasions to have a strong, lingering urine odour. Additionally, on August 29, 2014 after the resident's bathroom was cleaned, the strong urine odour was still apparent.

On September 3, 2014 Inspector #595 interviewed housekeeping staff # 107 who informed Inspector that they usually work on the floor where the inspectors noted the lingering odour. They confirmed that resident # 09's bathroom commonly has a strong lingering urine odour.

The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

Issued on this 29th day of September, 2014

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