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

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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
Jan 2, 2015	2014_331595_0010	S-000428-14	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 YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

MARINA MOFFATT (595), FRANCA MCMILLAN (544), JANET MCNABB (579), JESSICA LAPENSEE (133), MONIQUE BERGER (151)

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): October 6, 7, 8, 9, 10, 14, 15, 16, & 17, 2014

The following logs related to the Ministry of Health and Long-Term Care were also completed during the inspection: S-000466-14, S-000325-14, S-000385-14, S-000413-14.

During the course of the inspection, the inspector(s) spoke with the Senior Administrator, Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Food Service Supervisor (FSS), Infection Prevention and Control (IPAC) Designate, Acting Support Services Manager (ASSM), Housekeeping Staff, Maintenance Staff, Registered Staff, Non-Registered Staff, Residents and Family Members.

During the course of the inspection, the inspector(s) reviewed residents' health care records, reviewed various policies and procedures, conducted a daily walk-through of the home, observed the delivery of resident care and staff-to-resident interactions, observed medication administration, and observed the structural maintenance of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control program.

Inspector #544 observed lunch dining service on a specific unit of the home. Staff member #110 was observed to remove dirty plates from residents, proceed to the dessert cart and touch numerous desserts, and then serve them to various residents. Staff #110 did not wash or sanitize their hands after discarding dirty plates or before serving residents their dessert.

Inspector #544 observed staff member #111 during medication administration. Staff member #111 proceeded to assist a resident with their oxygen mask and then re-positioned them in their wheelchair. Staff member #111 left the room and proceeded to assist another resident in the hallway, and then administered medications to other residents. Staff member #111 did not sanitize or wash their hands in between these tasks or residents. It was noted by the Inspector that there was a bottle of hand sanitizer on the medication cart as well as alcohol-based hand rub pumps situated in resident rooms.

Staff member #111 then administered eye drops to a resident. After the administration, the staff member dropped the eye drop medication on the floor and then picked the medication up and placed it in the resident's designated bin. The staff member continued administering medication without washing or sanitizing their hands before or after administering the eye drops and after touching the contaminated bottle.

Staff member #111 continued to administer medication to three more residents and did not sanitize or wash their hands between residents.

Inspector #544 observed staff member #108 during medication administration. It was observed that the staff member did not wash or sanitize their hands in between residents while administering medications. [s. 229. (4)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c.8, s. 15(1) (c) in that at the time of the inspection, the program of maintenance services was not organized. This was evidenced by a lack of follow-up to the water infiltration that occurred in four identified bedrooms on October 3, 2014, and the lack of corrective actions taken with regards to roof drains on a particular wing, which had been ongoing for at least a year, and for which necessary equipment for repairs had been on site since May 2014.

On October 15, 2014, Inspector #133 observed a darkened ceiling tile at the entrance to a dining room. The Inspector proceeded down one hallway, and observed additional darkened ceiling tiles in the bathrooms for four resident rooms. Inspector #133 obtained a foot stool from the dining room and verified that all of the darkened tiles were wet. It was raining on October 15, 2014.

Inspector #133 asked three Personal Support Workers (PSWs) in the hallway, staff #131, #132 and #133, if the roof had been leaking. The PSWs explained that while there were wet ceiling tiles in some bathrooms, they had not observed water dripping from the tiles. On another note, the PSWs informed Inspector #133 that there had been water leaking into some bedrooms in the opposite hallway two weeks prior, on a day of heavy rains and strong winds. According to the PSWs, blankets and towels

were required to control the water and ensure resident safety. The PSWs clarified that the water had not come in from the ceiling, but from the lower walls in the back corner of the rooms. Staff #133 advised Inspector #133 that four resident rooms had been affected. Staff #133 reported that a particular resident room seemed to have been the most severely affected as water had leaked onto the floor under the resident's dresser and bed.

Later that afternoon on October 15, 2014, resident #008 alerted Inspector #133 that on the same rainy day, a lot of water had come in through the corner wall, pooling in between the two beds. Inspector #133 noted that the lower wall in this room and another resident's room just above the baseboard, was damp.

Inspector #133 went to speak with the Acting Support Services Manager (ASSM). The ASSM indicated they were not aware of the wet ceiling tiles on a particular resident care unit. The ASSM confirmed they had been made aware of one bedroom water infiltration issue, but was unable to speak to any follow up actions relating to the cause of the incident.

By October 16, 2014, the home's Senior Administrator (SA) had been made aware of the issues. It was confirmed in conversation with the SA on October 16, 2014 that, although front line staff had responded to the incident and ensured resident safety at the time, no follow-up action had yet been taken with regards to determining the cause, and they had not been made aware until the issue had been raised by Inspector #133. Although aware and involved in the immediate response, the home's Administrator had not pursued a root cause to the water infiltration in the four identified bedrooms.

On October 16, 2014 the SA informed Inspector #133 that they had looked into the issue of the wet ceiling tiles. The SA indicated that maintenance staff had assessed the problem in the past and determined a solution, had the required equipment to do the work on site, but they had not been able to complete the work due to competing priorities.

On October 17, 2014, the home's Administrator informed Inspector #133 that the equipment needed to do the roof drain repairs had been at the home since May 2014. Additionally, the Administrator clarified which bedrooms had been affected by the rain on Friday, October 3, 2014.

On October 17, 2014, a Maintenance Worker advised Inspector #133 that the bathroom ceiling tiles has been an ongoing issue throughout the past year. They explained to the Inspector that after a rain, staff know to check the ceiling tiles in the bathrooms of six resident rooms, of which two share bathrooms with another room. They explained that the elbows of the roof drains were leaking, and new clamps are needed to replace the old ones. The Maintenance Worker indicated they had not been previously aware of an issue in a specific resident room.

On October 17, 2014, Inspector #133 was informed by the SA that the home's roofing contractor had assessed that the wet ceiling tile at the entrance to a specific unit's dining room was due to a roof issue, and that work would be initiated to rectify the issue. Later that morning, the Administrator informed Inspector #133 that the roofing company had determined that there were some other roof issues as well, that they would go ahead and repair those issues, and that this may have contributed to the bedroom flooding on October 3, 2014.

In a telephone conversation with the home's Administrator on October 22, 2014, Inspector #133 was made aware that the roof drain repairs had been completed, the center roof had been repaired, and the perimeter of the opposite roof had been sealed. The Administrator further explained that the roofing contractor had found small but notable gaps in some areas around the perimeter of the opposite roof, and they now believe that this was the cause of the flooding, on October 3, 2014, in the four bedrooms. The Administrator also advised Inspector #133 that these four bedrooms do require drywall remediation, and that this would be scheduled as soon as possible. The Administrator said they still intended to have one side of the building's envelope assessed to ensure the bricks and mortar are intact.

The identified issues highlight disorganization within the maintenance services program at the time of the inspection, which in turn created a widespread potential risk to the home's residents. [s. 15. (1) (c)]

2. The licensee has failed to ensure that its furnishings and equipment are kept clean and sanitary.

During the noon day meal on October 6, 2014, Inspector #151 observed that residents were being plated food from adaptive lip plates. Inspector observed that many of these plates had heavy food staining, heavy scoring due to knife use and delaminating layers of plate surfaces. Inspector #151 obtained three of these plates and presented

them to the Assistant Director of Care (ADOC). [s. 15. (2) (a)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 plan of care set out clear directions to staff and others who provide direct care to resident #178.

Inspector #544 reviewed the health care record for resident #178. It was noted that the resident had excoriated areas since July 15, 2014. Inspector #544 identified that on September 25, 2014 the physician left an order for staff to follow the home's wound care protocol, which included weekly assessments for the excoriated areas.

Inspector #544 reviewed resident #178's care plan revised on August 13, 2014. It was noted that the care plan had not been updated by staff to reflect the new excoriated areas and related treatments. There was no focus, goal(s) or intervention(s) related to the excoriation. The sole intervention identified that Personal Support Workers (PSWs) were to report to Registered Staff should the excoriation become worse. There were however, weekly skin assessments conducted on resident #178 up to, and including, October 9, 2014, despite the fact that it was not identified in the care plan. Also, there was a physician's order which identified that the resident was receiving a topical ointment every three days.

There was no clear direction in the care plan for staff who provide direct care to resident #178, specifically pertaining to the excoriated areas. [s. 6. (1) (c)]

2. The licensee failed to ensure that the assessments of resident #178's wounds and use of bed rails were consistent throughout the plan of care.

Inspector #544 reviewed the health care record for resident #178. It was noted that the resident had excoriated areas since July 15, 2014. Inspector #544 identified that on September 25, 2014 the physician left an order for staff to follow the home's wound care protocol, which included weekly assessments for the excoriated areas.

Inspector #544 reviewed resident #178's MDS assessment conducted August 5, 2014. Under the section 'Other Skin Problems or Lesions present', Inspector #544 noted that resident #178's rashes were not identified in the MDS assessment. There were however, weekly skin assessments conducted on resident #178 up to, and including, October 9, 2014, despite the fact that it was not identified in the care plan.

In the same MDS assessment under 'Skin Treatments' there was no treatment identified for resident #178's excoriated areas, yet a physician's order identified that the resident was receiving a topical ointment every three days.

Inspector #544 observed that when resident #178 was in bed they had two full bed rails in the 'up' position. In the same MDS assessment of August 2014, Inspector #544 noted under 'Devices and Restraints' that there was no indication of resident #178's use of two bed rails. Upon review of the resident's health care record, it was discovered that there was a physician's order for these bed rails since November 21, 2012, a consent form signed by resident #178, and a full bed rail re-assessment completed on July 31, 2014.

The licensee failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #178 so that their assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the care plan was provided to resident #178 as specified in the plan.

Inspector #544 reviewed the care plan for resident #178 dated August 13, 2014. It was documented that resident #178 required the use of two long bed rails at all times when in bed. The care plan also identified that staff were required to check resident #178 every hour when the bed rails were engaged, and that safety checks, repositioning every 2 hours, and the resident's response were to be documented on the home's Restraint Record.

Inspector #544 reviewed the home's Restraint Record. There was no documentation on the following dates on various shifts: October 8, 9, 10, 11, 12, 13, and 14, 2014. The lack of documentation was confirmed by the Director of Care.

The care that is set out in the plan of care was not provided to resident #178 as outlined in the plan of care. [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 to ensure that the care plan for resident #178 provides clear directions to staff and others who provide direct care to the resident; that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #178 so that their assessments are integrated, consistent with and complement each other; and that the care set out in the care plan is provided to resident #178 as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there are appropriate furnishings and equipment in resident dining areas, including tables at an appropriate height to meet the needs of all residents, and appropriate seating for staff that are assisting residents to eat.

On October 6, 2014 Inspector #151 observed the noon meal service on a specific resident care unit of the home. Inspector observed that a particular table was tilted on an angle. Inspector touched the corner of the table and found that the table moved with minimal pressure. The tilt was sufficient to have table items shift. A staff member sitting at the table stated that they had to be careful when residents are eating at this table because of this issue.

On October 10, 2014 Inspector #544 observed the breakfast meal service on the same unit of the home. It was observed that the same table in the dining room was at a lower level than normal and noticeably tilted to one side. Inspector #544 was informed by staff member #117 that the Maintenance department was notified on October 9, 2014 @ 1315 hours to have this table removed or repaired. It was still being used the morning of October 10, 2014.

Inspector #544 observed that staff member #112 was sitting on a stool at a table feeding two residents. The stool was noticeably higher than the residents sitting at the table. The staff member had their legs crossed and their leg was level with the table. [s. 73. (1) 11.]

2. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking.

On October 6, 2014, Inspector #151 observed the noon meal service on a specific unit of the home. Inspector observed staff member #101 feeding all four residents at one table where they sat. Inspector spoke with staff member #101 who confirmed that on occasion two of the residents will feed themselves, however more often than not, all four residents require full assistance to eat their meal. [s. 73. (2) (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 there are appropriate furnishings in resident dining areas, including dining room tables, that they are at an appropriate height to meet the needs of all residents, that there is appropriate seating for staff who are assisting residents to eat, and that no person simultaneously assists more than two residents who need assistance with eating or drinking, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity was fully respected and promoted.

On October 6, 2014, Inspector #151 observed the noon day meal service on a specific resident care unit. Inspector observed a resident with their head bent forward with their nose dripping. Inspector #151 observed a staff member continue to feed the resident and neglected to address the nose drip. Inspector #151 observed one instance where the drip went onto the spoonful of food being fed to the resident. Inspector #151 advised the Director of Care (DOC) who, in turn, observed the resident being fed. [s. 3. (1) 1.]

2. On October 7, 2014, Inspector #151 observed resident #009 being transported from the spa room to their room. The resident was covered from the front; however their left side and buttocks were exposed. Inspector #151 advised staff member #107 of

the issue and the resident was quickly brought to their room without further shielding of the exposed areas. While in transport to the room, the resident had a bowel movement that fell to the floor in the hall, as they were being pushed in the shower chair. This incident was brought to the attention of the Administrator by Inspector #151. [s. 3. (1) 1.]

3. Inspector #151 observed an incident involving staff member #126 and resident #007 on a particular unit of the home. Staff member #126 was bent over the resident from behind the wheelchair and was saying loudly over their right ear, in an angry tone, "Jeepers creepers, you have got to quit wrecking the beds we make. It's not your bed. Go to your own bedroom. Jeepers creepers". The staff member was then observed pulling the resident out of another resident's room by the wheelchair and gave the resident a push down the hallway towards the resident's own room. A few minutes later, the staff member came back down the hallway and said, "so you found your own room after all".

This incident was brought to the attention of the Administrator who immediately sent staff member #126 home and commenced an investigation.

On October 15, 2014 Inspector #544 was informed by the DOC that staff member #126 was suspended for five days and would be assigned to another floor upon their return. The staff member was also asked to be mindful of their voice and attempt to develop methods whereby they can tone down their voice, and be cognizant of others and how they may perceive their tone of voice. [s. 3. (1) 1.]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents, and ensure that the policy is complied with.

Inspector #595 reviewed resident #377's progress notes from June 2013 until October 15, 2014. There was one documented instance of the resident coming forward to staff with concerns about another staff member. Specifically, on a particular day the resident informed the Registered Practical Nurse (RPN) that another staff member yelled at them, however the resident could not remember their name. This information was received by the Registered Nurse (RN) on shift who was asked by the RPN to speak with the resident. No further action was noted in progress notes.

Inspector #595 spoke with the DOC who stated that there was no Critical Incident (CI) submitted to the Director by the home for this particular case of alleged verbal abuse. They stated that staff did not bring the alleged abuse forward to management, therefore a CI/investigation was not conducted. They stated that the home would now initiate an investigation and submit a CI.

Upon review of the home's policy 'Resident Abuse - Staff to Resident' dated November 2013, it was stated that staff are to immediately report (verbally) any suspected or witnessed abuse to the Administrator, Director of Care, or their designate to the Ministry of Health and Long-Term Care (MOHLTC) Director through the Critical Incident Reporting System/after hours pager.

The licensee has failed to ensure that their policy related to 'Resident Abuse - Staff to Resident' was complied with. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that written policies and protocols are developed and implemented for the medication management system, specifically related to the administration of topical medication by unregulated and/or untrained staff members.

Inspector #544 reviewed resident #183’s care plan and noted an intervention under 'Pain' which stated to apply a specific cream to the affected area by staff if trained by registered nurse on the unit.

Inspector #544 interviewed three Personal Support Workers (PSWs) from three different resident care areas, who identified that, at times, they do apply topical medication to residents, although not trained by Registered Staff, and the topical medication is signed off as administered by the Registered Staff.

Inspectors #544 and #151 interviewed the Administrator who identified that they were aware of the delegation of applying topical medications to PSWs, however emphasized that it is not acceptable and staff are not complying with the home's current policy and procedure regarding medication administration.

The Administrator also confirmed that the home was currently developing a policy for the administration of topical medication by unregulated and/or untrained staff. [s. 114. (2)]

Issued on this 12th day of January, 2015

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARINA MOFFATT (595), FRANCA MCMILLAN (544), JANET MCNABB (579), JESSICA LAPENSEE (133), MONIQUE BERGER (151)
Inspection No. / No de l'inspection :	2014_331595_0010
Log No. / Registre no:	S-000428-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 2, 2015
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE YORK 333 YORK STREET, SUDBURY, ON, P3E-5J3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SANDRA MOROSO

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall ensure that all staff participate in the home's Infection Prevention and Control program, specifically the implementation of hand hygiene in the following situations: prior to and after resident contact, between resident contact during meal service, prior to and after medication administration to residents.

Grounds / Motifs :

1. The licensee has failed to ensure that staff participate in the implementation of the Infection Prevention and Control program.

Inspector #544 observed lunch dining service on a specific unit of the home. Staff member #110 was observed to remove dirty plates from residents, proceed to the dessert cart and touch numerous desserts, and then serve them to various residents. Staff #110 did not wash or sanitize their hands after discarding dirty plates or before serving residents their dessert.

Inspector #544 observed staff member #111 during medication administration. Staff member #111 proceeded to assist a resident with their oxygen mask and then re-positioned them in their wheelchair. Staff member #111 left the room and proceeded to assist another resident in the hallway, and then administered medications to other residents. Staff member #111 did not sanitize or wash their hands in between these tasks or residents. It was noted by the Inspector that there was a bottle of hand sanitizer on the medication cart as well as alcohol-based hand rub pumps situated in resident rooms.

Staff member #111 then administered eye drops to a resident. After the administration, the staff member dropped the eye drop medication on the floor and then picked the medication up and placed it in the resident's designated bin. The staff member continued administering medication without washing or sanitizing their hands before or after administering the eye drops and after touching the contaminated bottle.

Staff member #111 continued to administer medication to three more residents and did not sanitize or wash their hands between residents.

Inspector #544 observed staff member #108 during medication administration. It was observed that the staff member did not wash or sanitize their hands in between residents while administering medications.

During Inspection #2013_138151_0008 conducted in February 2013, the licensee had been issued a WN under s. 229(4). The licensee was issued a VPC during Inspection #2013_211106_0028 in September 2013. (544)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home;
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

Order / Ordre :

The licensee will prepare, submit and implement a plan for achieving compliance with LTCHA, 2007, S.O. 2007, c.8, s. 15 (1) (c). Specifically, that the maintenance program is organized in a way that ensures clear reporting of issues to, and follow up actions by, the person in the role of designated lead for maintenance services.

As oversight of the maintenance services program is in a time of transition, mechanisms must immediately be put into place that will ensure that the currently designated lead for maintenance services is made aware of any/all work that needs to be done but may not have been scheduled, and that schedules are put into place to ensure that the work is done. This is to include interviews with all maintenance workers in the home, in order to ascertain what they may know to be required work.

As well, in accordance with O. Reg. 79/10, s. 92 (2), the plan must address the qualification requirements for the position of the designated lead for housekeeping, laundry and maintenance services.

This plan must be faxed, to the attention of LTCHI Jessica Lapensée and Marina Moffatt, at (705) 564-3133. This plan is due on January 16, 2015, with completion of required program review and assessment by January 23, 2015.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S. O. 2007, c.8, s. 15(1) (c) in that at the time of the inspection, the program of maintenance services was not organized. This was evidenced by a lack of follow-up to the water infiltration that occurred in four identified bedrooms on October 3, 2014, and the lack of corrective actions taken with regards to roof drains on a particular wing, which had been ongoing for at least a year, and for which necessary equipment for repairs had been on site since May 2014.

On October 15, 2014, Inspector #133 observed a darkened ceiling tile at the entrance to a dining room. The Inspector proceeded down one hallway, and observed additional darkened ceiling tiles in the bathrooms for four resident rooms. Inspector #133 obtained a foot stool from the dining room and verified that all of the darkened tiles were wet. It was raining on October 15, 2014.

Inspector #133 asked three Personal Support Workers (PSWs) in the hallway, staff #131, #132 and #133, if the roof had been leaking. The PSWs explained that while there were wet ceiling tiles in some bathrooms, they had not observed water dripping from the tiles. On another note, the PSWs informed Inspector #133 that there had been water leaking into some bedrooms in the opposite hallway two weeks prior, on a day of heavy rains and strong winds. According to the PSWs, blankets and towels were required to control the water and ensure resident safety. The PSWs clarified that the water had not come in from the ceiling, but from the lower walls in the back corner of the rooms. Staff #133 advised Inspector #133 that four resident rooms had been affected. Staff #133 reported that a particular resident room seemed to have been the most severely affected as water had leaked onto the floor under the resident's dresser and bed.

Later that afternoon on October 15, 2014, resident #008 alerted Inspector #133 that on the same rainy day, a lot of water had come in through the corner wall, pooling in between the two beds. Inspector #133 noted that the lower wall in this room and another resident's room just above the baseboard, was damp.

Inspector #133 went to speak with the Acting Support Services Manager (ASSM). The ASSM indicated they were not aware of the wet ceiling tiles on a particular resident care unit. The ASSM confirmed they had been made aware of one bedroom water infiltration issue, but was unable to speak to any follow up actions relating to the cause of the incident.

By October 16, 2014, the home's Senior Administrator (SA) had been made aware of the issues. It was confirmed in conversation with the SA on October 16, 2014 that, although front line staff had responded to the incident and ensured resident safety at the time, no follow-up action had yet been taken with regards to determining the cause, and they had not been made aware until the issue had been raised by Inspector #133. Although aware and involved in the immediate response, the home's Administrator had not pursued a root cause to the water infiltration in the four identified bedrooms.

On October 16, 2014 the SA informed Inspector #133 that they had looked into the issue of the wet ceiling tiles. The SA indicated that maintenance staff had assessed the problem in the past and determined a solution, had the required equipment to do the work on site, but they had not been able to complete the work due to competing priorities.

On October 17, 2014, the home's Administrator informed Inspector #133 that the equipment needed to do the roof drain repairs had been at the home since May 2014. Additionally, the Administrator clarified which bedrooms had been affected by the rain on Friday, October 3, 2014.

On October 17, 2014, a Maintenance Worker advised Inspector #133 that the bathroom ceiling tiles has been an ongoing issue throughout the past year. They explained to the Inspector that after a rain, staff know to check the ceiling tiles in the bathrooms of six resident rooms, of which two share bathrooms with another room. They explained that the elbows of the roof drains were leaking, and new clamps are needed to replace the old ones. The Maintenance Worker indicated they had not been previously aware of an issue in a specific resident room.

On October 17, 2014, Inspector #133 was informed by the SA that the home's roofing contractor had assessed that the wet ceiling tile at the entrance to a specific unit's dining room was due to a roof issue, and that work would be initiated to rectify the issue. Later that morning, the Administrator informed Inspector #133 that the roofing company had determined that there were some other roof issues as well, that they would go ahead and repair those issues, and that this may have contributed to the bedroom flooding on October 3, 2014.

In a telephone conversation with the home's Administrator on October 22, 2014, Inspector #133 was made aware that the roof drain repairs had been completed, the center roof had been repaired, and the perimeter of the opposite roof had

been sealed. The Administrator further explained that the roofing contractor had found small but notable gaps in some areas around the perimeter of the opposite roof, and they now believe that this was the cause of the flooding, on October 3, 2014, in the four bedrooms. The Administrator also advised Inspector #133 that these four bedrooms do require drywall remediation, and that this would be scheduled as soon as possible. The Administrator said they still intended to have one side of the building's envelope assessed to ensure the bricks and mortar are intact.

The identified issues highlight disorganization within the maintenance services program at the time of the inspection, which in turn created a widespread potential risk to the home's residents. [s. 15. (1) (c)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 23, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 2nd day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Marina Moffatt

Service Area Office /
Bureau régional de services : Sudbury Service Area Office