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
Dec 18, 2013	2013_198117_0027	#O-000706-13 & #O-000852-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE PORT HOPE
360 Croft Street, PORT HOPE, ON, L1A-4K8

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 19, 20, 21, 22 and 28, 2013

It is noted that two (2) complaint inspection logs # O-000706-13 and # O-000852-13 were conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers (PSWs), an activity staff member, a physiotherapy aid, the RAI MDS coordinator, the social worker, the staffing scheduling clerk, several residents and several family members.

During the course of the inspection, the inspector(s) reviewed identified residents health care records, observed resident care and services, reviewed the home's Extendicare Port Hope Resident and Family Handbook, the staffing schedule for August, September, October and November 2013, the staff "on-call list" for staffing replacement August 13 to September 26, 2013; the DOC and ADOC "On-call" schedule for September 2013; the home's policy # 09-04-09 on Complaints ; the home's policy # ADMI-09-03-06 on Resident Medical Record; reviewed the administration's complaint/concerns process.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Medication
Personal Support Services
Reporting and Complaints
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 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).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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. The licensee failed to comply with the LTCHA 2007, C.8, s. 6 (1) (a) in that a resident's plan of care does not set out the planned care to the resident.

Resident #3 has a history of lower leg edema and was treated in September for an acute medical condition. On a specified day in September 2013, the attending

physician wrote an order for the resident to have compression stockings applied every morning and removed every evening. During the inspection, it was noted that Resident #3 was wearing compression stockings. Interviewed staff member S#113 stated that the resident does have edema to both legs and that this is monitored by registered staff. A review of the resident's current plan of care does not identify Resident #3's leg edema, the need to monitor the presence of edema and application /removal of compression stockings to both legs. [s. 6. (1) (a)]

2. Resident #3 has full and partial dentures. The resident also has some cognitive impairments and is known to frequently remove and misplace his/her dentures. Interviewed staff members S#111, s#113, S#109 stated on November 20, 2013 to Inspector #117, that Resident #3 will frequently remove and misplace his/her dentures prior to meal services. Although Resident #3's plan of care identifies the need for staff to ensure that the resident has dentures for meal services, the plan of care does not identify that the resident has behaviours linked to removing and misplacing his/her dentures. [s. 6. (1) (a)]

3. The licensee failed to comply with LTCHA 2007, c.8, s. 6 (4) (a and b) in that the staff and others involved in the different aspects of care of the resident did not 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 (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. (log #O-000852-13)

Resident #3 wears hearing aids and is noted to have some hearing difficulties. Correspondence from the resident's Power of Attorney (POA) to the home's administrator, on November 12 2013, indicates that a on specific date in early October 2013, the POA had expressed concerns with the cleaning of the resident's ears.

Six(6) days and then again 13 days after the initial concern was raised in early October, the resident unit nursing -physician communication book indicates that the resident #3's family requested mineral oil to the resident's ears to facilitate ear care. The physician visited the resident on a specified day in October 2013, and prescribed the use of mineral oil. The use of mineral oil for ear care was implemented at the time of the order.

No information was noted in the resident's chart regarding any concerns or follow up being done to review Resident #3's ear care during a two week period in October. Interviewed staff members S#105 and S#107 stated on November 21, 2013 that they were not aware of any other requests or concerns related to Resident #3's ear care other then concerns identified in the nursing-physician communication book. There was a lack of communication between the home's administration and nursing staff to assess Resident #3's ear care needs after the POA had expressed concerns on a specific dated in early October. Action was not taken until the physician's visit on a specific date in October 2013, 13 days after the initial concern was raised. [s. 6. (4) (a)]

4. The licensee failed to comply with LTCHA 2007, c. 8, s. 6. (7) in that nursing staff did not ensure that the care set out in the plan of care related to the provision of compression stockings is provided to the resident as specified in the plan. (log #O-000852-13)

On a specific day in September 2013 Resident #3's attending physician wrote an order for compression stockings. As per chart documentation, the order was faxed to the home's pharmacy provider Medico. Progress notes document that a voice mail message left to the resident's POA regarding the new order.

Eight (8) days later, Resident #3's POA was in contact with staff member S#114 regarding the status of the medical order for compression stockings. The staff member contacted the pharmacy provider to discover that the pharmacy does not stock compression stockings as these are not covered by the Ontario Drug and Benefit program (ODB). The staff member was informed that Resident #3's legs would need to be measured and an order placed with another pharmacy. As per staff member S#107 this info was shared with the POA, the leg measurements were taken and the order with measurements was faxed to the local Shoppers's Drug Mart one day later in September 2013.

In September, 11 days after the physician's order was made, progress notes document that the attending physician was inquiring about the status of the Resident #3's compression stockings as he had not seen any stockings on the resident's legs. The unit registered nursing staff advised the physician that the order and leg

measurements had been sent to Shoppers' Drug mart and had not yet received.

On a specific day in October, 13 days after the physician's order was made, the resident's POA called home regarding the status of the compression stockings. The POA was advised that the stockings had not yet been received. When the home conducted a follow up with Shopper's Drug Mart, the technician in charge of medical supplies had been away for several days and the order had not been processed. This information was shared with the POA who advised the home that he/she would get the stockings from another local pharmacy. Later that day, Resident #3's POA brought to the home compression support pantyhose for the resident

The following day, progress notes document a discussion between Resident #3's POA and staff member S#105 regarding compression stockings versus compression pantyhose which had been purchased by the family.

At the time of the inspection, Resident #3 had compression pantyhose applied to his/her legs.

The home failed to ensure that the resident receive his/her prescribed compression stockings in a timely manner. The resident received his/her stockings on a specified day in October 2013 with the assistance of his/her POA, 13 days after the compression stockings had been ordered by the attending physician. [s. 6. (7)]

5. The licensee failed to comply with LTCHA 2007, C.8, s. 6 (9) (1) in that the provision of care set out in the plan of care was not documented. (log #O-000852-13)

Resident #3 has a history of edema to both of his/herfeet. On a specified day in August, marked edema was noted to be present to both legs, going from toes to thigh. Resident #3's legs were assessed, no distress was noted. Physician on-call was notified and orders were received to closely monitor the resident's status.

For the next six (6) days in August, nursing staff documented their ongoing assessments of Resident #3's bilateral leg edema and the resident's health status. The resident was noted not to be in distress. It is noted that the resident was seen by his/her attending physician on 2 specified days in August 2013 during this time period. Physician notes indicate that the resident's health status and changes to the

resident's medication were discussed with the resident's POA, as one of the resident's cardiovascular medication can contribute to edema. Prescription changes were made to the resident's medication including request to hold the specified cardiovascular medication, decreased dosage to a neuroleptic medication and decreased dosage to a narcotic medication.

For two (2) days after the medication order changes, nursing staff did assess the resident's legs. Edema was noted on one of the legs and the resident's leg was measured. The resident was not in distress, POA and the resident's attending physician were made aware of the ongoing edema.

From the 3rd to the 10th day after the medication order change, there is no further documentation of ongoing nursing assessment and monitoring of resident's leg edema.

On the morning of the 10th day post medication change, chart documentation notes that one of Resident #3's legs was noted to be very edemateous, presenting with redness from the lower extremity to thigh. The resident's skin was warm to the touch. Resident #3 was noted to be complaining of discomfort. The on-call physician was notified and requested that Resident #3 be transferred to hospital for further assessment. The resident's POA was notified. The resident was transferred, assessed and returned to the home that same day with a diagnosis of an acute medical condition. [s. 6. (9) 1.]

6. The licensee failed to comply with LTCHA 2007, C.8, S. 6 (10) (b) in that the resident was not 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. (log #O-000852-13)

Resident #3 had an acute medical event that required hospitalization in August 2013. The resident returned to the home on a specified day in August 2013. Resident #3 progress notes document on a specified day in August, 1 week post return from hospitalization, that a PSW reported that the resident had some white spots on his/her tongue. The resident's family member expressed concerns regarding the resident's status. Documentation shows that nursing staff cleaned the resident's tongue with swabs and that the resident drank more fluids during meals. The unit nursing -

physician communication book documents that Resident #3's POA requested that the attending physician call him/her as he/she had concern with small white ulcer on the resident's tongue.

Five (5) days later, on a specified day in August 2013, a telephone order for an anti-fungal medication was received from the attending physician by staff member S#105. This order was later put on hold by the physician when the resident required to be transferred to the hospital for an urgent medical intervention reassessment. Upon the resident's return from the hospital, later that same day, the medical order for the anti-fungal medication was not reviewed. The medication was not renewed and was not given to the resident as per chart documentation.

A review of the resident's health care record, including daily care flow sheets for mouth care, does not mention of the status of the resident's tongue or the presence of white ulcers other then on one specified day in August 2013. Interviewed staff members S#109 and S#113 state that they do not recall seeing any white ulcers or spots on the resident's tongue during this period.

Staff member S#105 stated that he/she called the attending physician on a specified day in August 2013 as the PSWs had reported that the resident's mouth was presenting with signs of thrush. The staff member obtained an order for an anti-fungal medication but the order was then put on hold due to the resident's transfer to hospital. Staff members S#107 and S#105 state that they did not reassess the status of the resident's tongue after his/her return from hospital later that the day. Chart documentation does not identify the presence of possible signs and symptoms of thrush on the day of medication order in August 2013, nor after wards. Both staff members state that the anti-fungal medication was not re-prescribed by the attending physician. They stated to Inspector #117 that PSW staff did not report any other changes with the status of the Resident #3's mouth/tongue,including mouth pain or difficulty eating, to registered nursing staff after prior to and after that specified day in August 2013.

Nursing staff failed to re-assess Resident #3 mouth when PSW staff and resident's family member reported that the resident had white ulcers on his/her tongue on two specified days in August 2013 [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that Resident #3's plan of care sets out the resident's care requirements for staff as it relates to personal care items; that any new medical directives identified in the plan of care is provided to the resident; that there be communication and collaboration between the home's staff members to ensure that concerns with care are communicated and assessed in a timely manner; and that the resident's plan of care and interventions be reassessed when the resident's needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA s. 8 (3) in that there was not at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement. (log #O-000852-13)

Under O.Reg s. 45 (1) (2 ii), for homes with a licensed bed capacity of more than 64 beds and fewer than 129 beds, in case of an emergency where the backup plan referred to in clause 31 (3) (d) of this Regulation (staffing plan) fails to to ensure that the requirements under subsection 8 (3) of the Act is met, a registered nurse (RN) who works at the home pursuant to a contract or agreement between the licensee and employment agency or other third party may be used if,

A. the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by

telephone, and

B. a registered practical nurse who is both an employee of the licensee and a member of the regular nursing staff is on duty and present in the home.

Under O.Reg s. 45 (2) an "emergency" means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the home.

A review of the home's August, September, October and Novermber 2013 nursing staffing schedule was done. On the following dates, there was no Registered Nurse (RN) noted to be working in the home

• September 2, 2013 : There was no RN in the home between 7am and 3 pm. It is noted that there was an extra RPN working in the home and that the ADOC was on-call.

• September 10, 2013 : there was no RN in the home between 10pm and 11pm. It is noted that the ADOC was on call during this period of time until the night RN arrived to work at 11pm.

• September 11, 2013 : There was no RN in the home between 7pm and 11 pm. It is noted that there was an extra RPN working in the home and that the ADOC was on-call.

• September 26, 2013: There was no RN between 11pm and 7 am. It is noted that there was an extra RPN working in the home and that the ADOC was on-call.

On November 20 and 21, 2013, the home's Administrator and Director of Care stated that in mid-August 2013, two long time RNs had unexpectedly left their employment with the home. The home's staff schedule was adjusted to ensure 24-RN nursing coverage during the home's RN recruitment. However, there were 4 days, when RNs schedule to come to work were unable to do so. Scheduling clerk and DOC did try to cover these periods by contacting staff on the "on-call list". However they were unsuccessful in covering the RN shifts for the above time periods.

The home did have an RN on-call (ADOC and DOC) and did ensure that an extra Registered Practical Nurse (RPN) was working in the home during these identified periods. The home's Administrator stated that the home does not have a contract with

a staff agency and could not access external RN staffing services.

Since October 1, 2013, the home has been able to hire new RNs and there have been no other problems with ensuring RN coverage at all times within the home. [s. 8. (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 there is a registered nurse, who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there is an allowable exception to this requirement, to be implemented voluntarily.

WN #3: 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:
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).

Findings/Faits saillants :

1. The licensee failed to comply with the LTCHA 2007, c. 8, s. 3 (1) (14) in that residents' right to receive visitors of their own choice and consult in private without interference was not respected. (log # O-000706-13)

Resident #1 and Resident #2 have been living at the long term care home for the past few years. Both Residents #1 and #2 are competent and are capable of making decisions regarding whom they choose to have as visitors. During this period of time, they developed a friendship with another resident's paid companion.

In June 2013, the other resident's family relieved the paid companion of his/her services as safety concerns were identified with the paid companion. At that time, the home's Administrator verbally informed the paid companion that he/she was not

allowed to enter the long term care home to visit any other residents within the home.

In June 2013, Resident #1, Resident #2 and their family member were informed by the Administrator that the paid companion was not allowed to visit any resident within the long-term care home due to identified safety concerns. Both residents were upset about not being allowed to receive this specific visitor. Resident #1 continued to have regular telephone contact with the paid companion. On several occasions, he/she expressed to his/her family member and the home's administration that he/she would like to receive visits from the paid companion, however this could not occur as per home's directives.

On November 19 and 20, 2013, Resident #1 and Resident #2 told Inspector #117 that they had both recently met and visited with the paid companion at a location outside of the home, in October 2013. They expressed that they did not have safety concerns regarding the paid companion. They both stated that they would like to receive visits from the paid companion at the long term care home, but that home's directives are restricting their ability to receive his/her visitation within the home. The paid companion's restriction from visitation was confirmed by the home's Administrator and Director of Care on November 19 and 20, 2013.

On November 28, 2013, Resident #1 and Resident #2's family member also informed Inspector #117 that he/she had no concerns regarding the paid companion's ability to visit the residents. The family member stated that he/she supported the residents wish to be able to receive the paid companion as a visitor.

The licensee failed to ensure that Resident #1 and Resident #2 have the right to receive visitors of their choice without interference. [s. 3. (1) 14.]

WN #4: 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 failed to comply with O.Reg. 79/10 s. 131 (2) in that a drug was not administered to a resident in accordance with the directions specified by the prescribed. (log #O-000852-13)

Resident #3 was prescribed a narcotic medication patch for pain management on specified day in August 2013. As per medication administration records (MAR), the narcotic medication patch was applied and removed as per medical orders.

On a specific day in September 2013, the attending physician discontinued Resident #3's narcotic medication. As per chart documentation, the medication order was processed by staff member S#107. The medication was removed from the medication cart and noted to be discontinued in the resident's medication administration record. On a specified day in October 2013, 7 days after the medication was discontinued, staff member S#115 and resident's POA noted that the resident still had on an arm a narcotic medication patch with a date of 10 days ago. As per the resident's MAR, a specified day in September is the last date on which a new narcotic medication patch was administered to the resident. The narcotic medication patch was not removed on the day the medication was discontinued, as per medical orders.

On November 21, 2013, the home's DOC confirmed that the medication error was reported to the home's administration when it was discovered in October 2013. The home did conduct an internal investigation into the medication error. The DOC confirmed that staff member S#107 did not remove the last medication patch from the resident's skin when the medication was discontinued on a specified day in September 2013. The medication error was reported to the resident's POA on a specified day in October 2013. The resident was assessed and no adverse effects were noted. [s. 131. (2)]

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Issued on this 19th day of December, 2013

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

Lynn Duchesne #117