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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 14, 2016	2016_551526_0018	031766-15	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 BRAMPTON
7891 Mclaughlin Road BRAMPTON ON L6Y 5H8

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

THERESA MCMILLAN (526)

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 23, 24, 25, 28, 29, 30, and December 1, 2, 6, 2016.

This inspection was conducted simultaneously during the home's RQI Inspection intake #031882-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Inventory (RAI) Coordinator, the Skin and Wound Registered Practical Nurse (RPN), RPNs, Personal Support Workers (PSWs), the Food Services Supervisor (FSS), the Dietary Supervisor, the Housekeeping/Laundry Supervisor, and family member.

During the course of this inspection Inspector(s) reviewed health records, investigative notes, complaints log, policies and procedures, training records, and menus.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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. 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).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

According to their health record, and interview with Registered Practical Nurse #107, resident #024 was at risk for an alteration to skin integrity. On a specified day in 2015, the resident developed a health condition, was provided care while in bed, and had an increased risk for altered skin integrity.

The following day, the document the home referred to as resident #024's care plan was updated to indicate the assistance that was required with positioning while in bed; the plan of care in relation to the resident's change in health condition was outlined in progress notes. On that same day, the resident's family member expressed concern about the resident's risk for altered skin integrity and requested specific strategies be initiated; no assessment was completed and the strategies were not implemented according to progress notes.

There was no 'Point of Care' (POC) documentation that the resident was turned and positioned over an eight day period, however, progress notes included entries that they were repositioned frequently. One note indicated that they were to be repositioned every four hours during the night and every two hours during the day.

According to progress notes, the resident developed an area of altered skin integrity; care continued as before and an additional skin and wound intervention was initiated the following day. No other plan of care entries in relation to the resident's altered skin integrity were found in the health record. The area of altered skin integrity worsened, the resident was admitted to hospital and deceased.

The home's "Wound Care Management" policy number RC-06-12-02 last revised July 2016, directed staff to "develop and implement an individualized interdisciplinary care plan in collaboration with resident/POA/SDM/family to address identified risk factors, promote healing, prevent infection and reduce pain and discomfort" with care areas to be included.

Review of the document the home referred to as resident #024's care plan did not include an individualized interdisciplinary care plan regarding the resident's newly developed area of altered skin integrity. During interview, RPN #106, who was the home's skin and wound champion confirmed that the current written plan of care for resident #024 did not set out the planned care in relation to the deterioration in skin

integrity. They confirmed that the home failed to ensure that there was a written plan of care for resident #024 that set out the planned care for the resident in relation to altered skin integrity. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

According to the home's health record, resident #024's plan of care included the administration of two interventions to help manage a health condition. On a specified day in 2015 the resident's condition changed. The following day a physician progress note and a note by Registered Practical Nurse (RPN) #107 indicated that one of the interventions should be held due to the change in condition. The Director of Care (DOC) and RPN #106 confirmed that registered staff did not put a hold on the intervention or follow the physician's direction, which would have prompted a change in directions at the time of its administration. However, review of the electronic medication administration record (eMAR) indicated that resident #024 had received the intervention on at least three out of six days after it was to be held. During interview, RPN #107 confirmed that the resident should not have received the intervention on those days.

The eMAR also indicated that the resident was to receive a second intervention. Their family reported to the LTC Inspector that they were concerned that the resident had not been receiving it. Progress notes indicated that the intervention had been administered on four occasions over eight days, but held the rest of the time due to the resident's change in condition. RPN #106 confirmed that registered staff had not indicated in the eMAR whether the intervention should have been held or continued. During interview, the DOC and Administrator confirmed that the directions were unclear regarding the administration of two interventions when resident #024 had a change in condition. [s. 6. (1) (c)]

WN #2: 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. The licensee 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 were documented.

According to health records and interviews with RPN #107 and PSW #119, resident #024 was at risk for altered skin integrity. On a specified day in 2015, they had a change in their health condition, were provided care in bed, and had an increased risk for altered skin integrity. At that time, their plan of care indicated the assistance that was required with turning and positioning while in bed. Other than one note that indicated that the resident was to be repositioned every four hours during the night and every two hours during the day, the plan of care did not specify the frequency that staff should have turned and positioned resident #024. They were assessed as having developed an area of altered skin integrity which worsened. During interview, resident #024's family member expressed concern that the resident was not turned and repositioned sufficiently while in bed and that this lead to a deterioration in skin integrity.

Interviews with PSW #119 and RPN #107, and progress notes over eight days, indicated that the resident was turned and repositioned frequently. However, there was no documentation of turning and positioning during 16 shifts during these eight days; the PSW "point of care" (POC) documentation had not been completed during this time frame. The RAI Coordinator, DOC and Administrator stated that staff should have documented at least each shift that the resident had been turned and positioned and how often. They confirmed that staff had not documented that resident #024 was turned and repositioned on every shift over an eight day period. [s. 30. (2)]

Issued on this 4th day of January, 2017

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

Original report signed by the inspector.