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
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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 10, 2014	2014_283544_0031	S-000477-14	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

FRANCA MCMILLAN (544), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)

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): November 3, 4, 5, 6, 7, 10, 12, 13, 2014 related to

S-000477-14
S-000420-14
S-000417-14
S-000417-14
S-000400-14
S-000446-14
S-000529-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Assistant Director's of Care, Registered Staff, Personal Support Workers, Dietary Manager, Dietary Staff, RAI/MDS Co-ordinator, Kinesiologist, Maintenance Manager, Activity Co-ordinator, Housekeeping Staff, Infection Control Co-ordinator and Physiotherapist, Family Council President and Resident Council President.

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

During the course of this inspection, Non-Compliances were issued.

9 WN(s)
4 VPC(s)
1 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.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. Inspector #575 reviewed 2 Complaints Logs from Residents' family members regarding insufficient staffing in the home. During the course of the inspection, Inspectors received multiple complaints from Residents, family and staff regarding insufficient staffing.

The home's staffing plan was provided to the Inspector. Staff # 101 told Inspector # 575 that the staffing plan is determined based on the care needs of the Residents. The Inspector reviewed the staffing plan and identified that the planned deployment of direct care staff was not met on a daily basis in September and October 2014.

The following was the planned staffing mix:
PSWs: 27 on days (2nd floor 8, 3rd floor 10, 4th floor 9), 27 on evenings (2nd floor, 5 @ 5.5 hours, 3 @ 7.5 hours), (3rd floor, 7 @ 5.5 hours, 3 @ 7.5 hours), (4th floor, 6 @ 5.5 hours, 3 @ 7.5 hours), 6 on nights, (2 on each floor).
RPNs ; 6 on days and evenings (2 on each floor) and 3 on nights (1 on each floor).
RNs: 3 on days, 2 on evenings and 1 on nights.

Inspector spoke with Staff #104 who stated that staff "call ins" are communicated via the "Communication Sheet for Staffing" and identifies whether the staff member was replaced or not and that this form was most accurate when determining how many staff were not replaced. Inspector # 575 reviewed the home's communication logs for the month of September 2014 and October 2014.

During the month of September 2014, the home was at least one staff short every day 30/30 (24 hour period). 21/30 days, the home was two (2) or three (3) staff short. 7/30

days, the home was short staffed up to six and seven (6&7) staff in a 24 hour period.

During the month of October 2014, the home was at least one staff short every day 31/31 (24 hour period). 11/31 days, the home was two (2) and three (3) staff short. 7/31 days, the home was short staffed up to six and seven (6&7) staff in a 24 hour period.

The home has a back-up plan (Plan A, B, C, D) for staff shortages which involves re-assigning staff to another unit in order to achieve equal staffing on each unit.

In reviewing the staff that were working the days in September and October 2014 and the back-up plan, Inspector identified that the home deployed Plan B (one staff short), every day in September 30/30 days, and 31/31 days in October 2014. Plan C was deployed 11/30 days in September and 11/31 days in October 2014, (2 staff short). Plan D was deployed 13/30 days in September and 11/31 days in October 2014, (3 or more staff short).

Inspector #575 interviewed direct care staff throughout all resident care units of the home. Staff #125, #126, and #109 from a resident care unit told Inspector that during weekends the unit is usually 2-3 staff short and as a result "staff do not take their breaks or come in early (on their own time) to get the Residents' care done." Staff #109 stated that when they are short staffed, staff attempt to get all the Resident's care needs completed however, if they are unable to, bathing and shaving would be put off until the next day and Residents would have longer wait times for care. The staff members also stated that there is often not enough staff to assist with transferring Residents who require 2 staff therefore, Residents are required to wait for long periods of time.
Staff #127, from a resident care unit, told Inspector that the unit is usually at least 1 staff short on a daily basis.
Staff #128 from another resident care unit stated that the unit is usually Plan B (1 staff short) every other day and that weekends are worse.

Resident # 6520 told Inspector #575, during an interview, that they normally do not have to call for assistance because they are independent however, one night, they had to wait an hour after ringing the bell for assistance for care. Inspector reviewed the call bell log for Resident #6520. Inspector identified that, on that night, the call bell was pressed at 6:23 pm and was answered 47:11 minutes later. Review of the communication sheet identified that the home was 6 PSWs short staffed on evenings, and specifically 2 staff short (Plan C) on Resident #6520's care unit that evening. The Resident's care plan identified that the Resident "may require limited assistance at times for toileting, transfers

and the Resident is encouraged to ring the call bell for assistance when needed."

Resident #6506 told Inspector #575 that they required staff assistance with toileting and a few weeks ago had to wait 30 minutes on the toilet after ringing the call bell, waiting for staff to assist. Inspector reviewed Resident # 6506's progress notes and identified that the Resident was "very upset and expressed to the PSW that they were left on the toilet." This has happened before according to the Resident. Inspector reviewed the Resident's washroom call bell log on the day of the incident and noted that the call bell was not answered for 15:38 minutes. The Resident's care plan identified that the "Resident requires extensive assistance of 1 staff for toileting and that the resident can be left unattended and will ring the call bell for assistance when finished."

Inspector # 575 reviewed a Complaint filed by a family member on behalf of Resident #007. The family member approached Inspector #575, during the inspection, and stated that the home is constantly short staffed, often in Plan B, C or D (1 short, 2 short, 3 short respectively). The family member stated that Resident #007 was in a "split section" so when a worker does not show up for work, the caregiver is pulled to another section and Residents are added to their workload "on top" of their current assignment which means those Residents are divided up amongst the remaining sections. Resident #007 has no consistency of care and has to wait a long time for assistance. Inspector reviewed the call bell log for a period of time. The Inspector noted on multiple occasions Resident #007's call bell was not answered for over 10 minutes. Review of the most recent care plan identified that the Resident # 007 "requires extensive assistance of 2 staff with a mechanical lift for toileting on demand and for transfers from their bed to wheelchair and is able to use the call bell for assistance."

Inspector reviewed a Complaint filed by a family member for Resident #006. The family member identified that the Resident uses the call bell for assistance for their incontinent product to be changed, for repositioning, and for medications. The Resident advised the family member that they are required to wait for extended periods of time for staff assistance, especially on night shifts. The family member stated that the home is constantly short staffed and the resident waits 20-30 minutes for assistance. Inspector reviewed the call bell log for the period of one week and noted that the Resident's call bell was routinely not answered in a timely fashion. The Resident's call bell was not answered for 10-15 minutes 35/335 activations and not answered for more than 15 minutes on 32/335 activations with 2 occasions exceeding 1 hour. Review of the Resident's most recent care plan identified that the Resident required extensive assistance of 2 staff for repositioning in bed, for incontinent product changes and

required close monitoring to ensure the Resident's head of the bed remained elevated.

Inspector #575 reviewed the home's policy titled "Nurse Call System" and noted the call system is available for the safety and convenience of Residents and that staff are to respond to calls "in a rapid and courteous manner." The call bells are only de-activated after responding to the call. During an interview with Staff # 101, Staff # 101 told Inspector that ideally call bells should be responded to within 2 minutes.

A family member representing Resident #6331 told Inspector #544, during a family interview, that, on occasion, they have observed Resident #6331's "eyes crusted, food on their face, mucous in their nostrils and that it looks like staff have rushed through the Resident's morning care and did not take extra care or time."

Staff # 129 told Inspector # 575 that staff shortages occur on a daily basis and that the Residents do not get the appropriate care because staff are rushed. The staff member indicated that they have no time to greet Residents and that they have noticed some Residents have had escalating responsive behaviours due to feeling rushed. Staff # 129 further indicated that staff shortages are ultimately hurting the Residents by causing the Residents to wait for long periods of time for assistance.

The home has displayed a pattern of insufficient staffing as determined by the above findings.

The licensee has failed to ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the residents. [s. 8. (1)]

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 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. The licensee has failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

Inspector # 575 and Inspector # 543 identified offensive odours on specific resident care areas, in several resident's rooms and resident care areas throughout the home.

Inspector # 544 identified strong offensive odour of urine in certain bathrooms where caulking was missing around the toilet bowls and the area between the toilet tank and the toilet bowl, where the safety support bars were situated, there was black caked grime. In some bathrooms, there was also urine seeping between the cracks of the vinyl flooring.

Staff # 110 stated that the area between the bowl and the toilet tank, where the safety bar is attached, was not on the daily, weekly or monthly cleaning schedule. The toilet safety bars are now being removed and being replaced by a different safer type of bar.

Inspector # 544 identified that rooms on certain resident care units had an odour of urine in the bathroom. This odour has been present for the last several days despite housekeeping staff cleaning these bathrooms three times a day. The caulking around the toilet bowl was missing, there was dried urine on the floor and stains of urine on the vinyl flooring in the bathroom and the floor was "sticky." [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #3: 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. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. Inspector # 575 observed a medication administration pass to Resident # 005 by Staff # 106. During the medication pass, Staff # 106 performed blood glucose testing via the use of a glucometer. Staff # 106 did not perform hand hygiene or use gloves during this procedure.

Inspector # 575 interviewed Staff # 123 regarding the policy/procedure during blood glucose monitoring, specifically if staff were to wear gloves during the procedure. The staff member later provided Inspector with the home's policy titled, "Monitoring Blood Glucose" last reviewed December 2002. It indicated staff are to apply gloves before performing glucometer testing. Staff # 123 further stated that the policy was outdated to the home's current practice of hand hygiene and no use of gloves. Staff # 123 confirmed that the policy needed to be updated.

The licensee has failed to ensure that the written policies and protocols related to the medication system are updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 114. (3) (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 the written policies and protocols related to the medication system are updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Inspector # 575 observed a medication storage area on a resident care area with Staff # 121. The following is a list of expired medications found in the medication cart:
1.) Senekot 1000 tabs expired October 2014;
2.) Koffex DM expired September 2014;
3.) Desonide 0.05% prescription cream was opened October 16, 2014. The expiry date on the cream was noted as August 2014. It was opened and used after the expiry date. In addition, Inspector noted that 10/13 insulin pens were not labelled with the date they were first opened. Staff # 121 told Inspector that the insulin pens should be labelled when they are opened because the pens are to be stored in the medication cart for a period of 1 month once removed from the refrigerator. Staff # 123 provided Inspector with a policy from Medical Pharmacies titled 'How to Administer Insulin' dated January 2014 that indicated that "insulin can be kept at room temperature for 28 days" and "ensure that new vials are dated with date opened/discard after sticker".

The licensee has failed to ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs (e.g. expiration dates, refrigeration, lighting). [s. 129. (1) (a)]

2. Inspector # 575 toured and made observation of a medication room on a resident care area with Staff # 121. Inspector noted that narcotics were stored in two locations. Staff # 121 showed Inspector that narcotics are stored in a separate locked area within the locked medication cart and also in a separate locked stationary cupboard within the locked medication room. Inspector noted that the separate stationary cupboard was not double-locked within the locked medication room. Inspector confirmed with Staff # 122 that narcotics were placed in the medication cart when needed for a medication round and were stored within a single locked cabinet in the medication storage area.

The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, that is secure and locked, that protects the drug from heat, light, humidity or other environmental conditions in order to maintain efficacy and that complies with manufacturer's instructions for storage of the drugs and that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: 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. Inspector # 575 observed medication administration pass by Staff # 106 to three (3) Residents (#003, 004, and 005). Staff # 106 did not perform hand hygiene before or after administering medication to Resident # 003 and proceeded to administer medication to Resident # 004 and #005, that included the administration of eye drops and glucometer testing, without performing hand hygiene until after administration to the third Resident # 005.

Inspector # 575 interviewed the home's Infection Prevention and Control lead Staff #119, who told Inspector, that during medication administration the expectation is that hand hygiene is completed before and after administration and that staff are aware of the 4 moments of hand hygiene (before and after resident contact, before aseptic technique, and after bodily fluid exposure). Staff # 120 also confirmed to Inspector, that during medication administration, hand hygiene should be completed before and after each Resident who is receiving medication.

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

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #6: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

Resident # 6331 has been in the home for several years. Resident # 6331 had stated several times to their POA that they would like a tub bath instead of bed baths all the time. Resident # 6331 told the POA that they did not feel clean enough, feels uncomfortable and dislikes bed baths all the time.

In a family interview, Resident # 6331's POA told Inspector # 544 that Resident # 6331 would "love a tub bath now and again but staff stated that, with Resident # 6331's present medical condition, it would be difficult to to do so."

Inspector # 544 reviewed Resident # 6331's care plan. There was a care conference held where the POA brought up the issue of a tub bath/shower. The response given to the POA was that it was too difficult to give Resident # 6331 a shower or tub bath due to their medical condition.

Inspector # 544 interviewed Staff # 101 and Staff # 113 who stated that the home had recently purchased a new type of sling that could assist with bathing and positioning of all Residents during a tub bath or shower. Staff # 113 felt that it may be possible to complete a tub bath for Resident # 6331, but wanted to ensure safety for the Resident and staff and will complete an assessment. If possible, a tub bath would be provided to Resident # 6331.

Inspector # 544 reviewed Resident # 6331's care plan and identified the goal as, " * Resident # 6331 will be showered 1X per week, throughout the review period. " However, the intervention was written as, "Bathing: TOTAL DEPENDENCE X 2 STAFF: wash their hair in the shower room. Then staff transfer Resident # 6331 to have a bed bath."

Staff # 114, 115 and # 116 confirmed that they provide a bed bath to Resident # 6331 and not a shower.

Resident # 6331's POA also confirmed that staff are not showering Resident # 6331.

Staff # 101 confirmed that this was not clear direction to staff as staff are not showering Resident # 6331.

WN #7: 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. Inspectors #543 and #544 while performing Resident observations, observed safety concerns related to several toilet support rails in several residents' bathrooms. Many wobbly and/or unsafe toilet support rails were observed throughout the home. An audit was conducted and 10/10 toilet support rails were found to be unsafe.

Inspector # 543 brought concerns regarding the toilet support rails to Staff # 100. Inspector explained that several toilet support rails were extremely wobbly, that the securing devices attached to the toilet were also loose and in need of repair. Inspector also informed Staff # 100 that in one of the bathrooms, the toilet support rail was not even attached to the toilet. It was leaning against the wall at the back of the toilet. Staff # 100 confirmed that these rails were unsafe and need to be replaced. Staff # 100 stated that she would be looking into obtaining a new type of toilet support rails. immediately.

Inspector # 543 spoke with Staff # 108 in regards to the toilet support rails in the bathrooms that were observed to be loose and in disrepair. Staff # 108 confirmed that this should have been reported to maintenance for repair. They stated that on each unit there is log book for maintenance. All staff are to regularly document any repairs or maintenance concerns that need to addressed. There are log books in the main office and the staff lounge also. The staff are aware that these log books are available and it is common practice for staff to communicate using these books. Staff # 108 was not made aware of the loose toilet support rails in the bathrooms and agrees that these concerns

should have been brought forward. Staff # 108 confirmed that the maintenance staff check each log book a minimum of once a day.

Inspector # 543 spoke with three (3) different staff personnel from different departments regarding how to report issues or concerns regarding repairs or maintenance. All three confirmed that on every unit there is "Maintenance Log" that staff are to document any concerns regarding repairs or any other issue related to maintenance. The staff also confirmed that maintenance staff check the log book twice a day.

Inspector # 543 reviewed the maintenance log books, for several months, from different resident care units where the loose toilet support rails were observed and identified that there was no documentation of loose toilet support rails or need for repair.

Inspector # 543 reviewed the home's Policy-Preventive Maintenance (MNTC-01-01-03). This policy's stated purpose establishes a requirement for a program that provides remedial maintenance for the building and the equipment and systems that are part of the building. This policy stated that, "all homes shall have a remedial maintenance program that provides a system of routine inspections and repairs to the building components including the equipment and systems that are part of the building. These include, but are not limited to electrical and non-electrical equipment, mechanical lifts, plumbing fixtures, washroom fixtures, toilets, sinks and grab-bars, temperature of hot water serving bathtubs, showers and hand-basins used by residents and mechanical ventilation systems."

The licensee failed to ensure that the home's equipment is maintained in a safe condition and in a good stated of repair. [s. 15. (2) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident # 6331 is bathed by the method of their choice.

In a family interview, Resident # 6331's Power of Attorney (POA), stated to Inspector # 544 that Resident # 6331 would love a tub bath now and again but staff stated that it would be difficult to give Resident # 6331 a tub bath due to their medical condition.

Resident # 6331 has been in the home for several years. Resident # 6331 is being cared for at the home at their request. However, Resident # 6331 stated stated to her POA that they would like a tub bath instead of bed baths all the time. They do not feel clean enough, feels uncomfortable and dislikes bed baths all the time.

Inspector # 544 interviewed Staff # 101 and Staff # 113 who stated that the home had recently purchased a new type of sling that could assist with bathing and positioning of Residents. They will assess Resident # 6331 to see if perhaps a tub/shower bath is appropriate for Resident # 6331. Staff # 113 felt that it may be possible but wanted to ensure safety for all Residents and staff and will complete an assessment and trial a tub bath.

Staff # 114, 115 and Staff # 116 all confirmed that Resident # 6331 is given bed baths and not a tub bath or shower.

Inspector # 544 reviewed Resident # 6331's care plan and identified that a care conference was held where the POA brought up the issue of a tub bath/shower for Resident # 6331. The response given to the POA was that it was too difficult to give Resident # 6331 a shower or tub bath due to their medical condition.

Inspector # 544 was approached by Staff # 101. Staff # 101 told Inspector that Resident # 6331 had a tub bath. Staff were able to bath Resident # 6331 safely in the tub room. Staff will continue to provide Resident # 6331 a bath of their choice.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff are provided annual training in falls prevention and management.

Inspector # 544 reviewed a Critical Incident Report
Resident # 002 had a fall and sustained a fracture.
Inspector # 544 also identified in the progress notes that Resident # 002 had a previous fall that did not result in an injury in 2014.

Inspector # 544 reviewed a Critical Incident Report.
Resident # 001 had a fall that resulted in a fracture.
Inspector # 544 also noted in the progress notes that Resident # 001 has had several falls in 2014.

Staff # 101 confirmed that there were approximately 260 staff members in the home of which 150 staff provide direct care to Residents (i.e. Registered Staff and Personal Support Workers).

Staff # 123 provided Inspector # 544 with staff education attendance records for the Falls Prevention and Management Program and identified:
104/150 direct care staff were trained in Falls Prevention Management Program in 2013
62/150 direct care staff were trained thus far in Falls Prevention and Falls Management Program for 2014.

Staff # 125 told Inspector # 544 that it is difficult to get all staff to adhere to the Staff education/training that is required regarding Falls Prevention and Management. [s. 221. (1) 1.]

Issued on this 11th day of December, 2014

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

Original report signed by the inspector.

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) :	FRANCA MCMILLAN (544), LINDSAY DYRDA (575), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2014_283544_0031
Log No. / Registre no:	S-000477-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 10, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE FALCONBRIDGE 281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Louise Arbour

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The home shall prepare, submit and implement a plan to ensure that there is a there is, (a) an organized program of nursing services for the home to meet the assessed needs of the residents; and (b) an organized program of personal support services for the home to meet the assessed needs of the residents.

This plan must be submitted in writing to Inspector Franca McMillan at 159 Cedar Street, Suite # 403, Sudbury, Ontario. P3E 6A5 of by fax at 705 564-3133 on or before January 16, 2014.

Grounds / Motifs :

1. Inspector #575 reviewed 2 Complaints Logs from Residents' family members regarding insufficient staffing in the home. During the course of the inspection, Inspectors received multiple complaints from Residents, family and staff regarding insufficient staffing.

The home's staffing plan was provided to the Inspector by Staff # 101. Staff # 101 told Inspector # 575 that the staffing plan is determined based on the care needs of the Residents. The Inspector reviewed the staffing plan and identified that the planned deployment of direct care staff was not met on a daily basis in September and October 2014.

Inspector spoke with Staff #104 who stated that staff "call ins" are communicated via the "Communication Sheet for Staffing" and identifies whether

the staff member was replaced or not and that this form was most accurate when determining how many staff were not replaced. Inspector # 575 reviewed the home's communication logs for the month of September 2014 and October 2014.

The following was the planned staffing mix:
PSWs: 27 on days (2nd floor 8, 3rd floor 10, 4th floor 9), 27 on evenings (2nd floor, 5 @ 5.5 hours, 3 @ 7.5 hours, (3rd floor, 7 @ 5.5 hours, 3 @ 7.5 hours), (4th floor, 6 @ 5.5 hours, 3 @ 7.5 hours), 6 on nights (2 on each floor).
RPNs ; 6 on days and evenings (2 on each floor) and 3 on nights (1 on each floor).
RNs: 3 on days, 2 on evenings and 1 on nights.

Inspector spoke with Staff #104 who stated that staff "call ins" are communicated via the "Communication Sheet for Staffing" and identifies whether the staff member was replaced or not and that this form was most accurate when determining how many staff were not replaced. Inspector # 575 reviewed the home's communication logs for the month of September 2014 and October 2014.

During the month of September 2014, the home was at least one staff short every day 30/30 days. 21/30 days, the home was two (2) or three (3) staff short. 7/30 days, the home was short staffed up to six and seven (6&7) staff in a 24 hour period.

During the month of October 2014, the home was at least one staff short every day 31/31 days. 11/31 days, the home was two (2) and three (3) staff short. 7/31 days, the home was short staffed up to six and seven (6&7) staff in a 24 hour period.

The home has a back-up plan (Plan A, B, C, D) for staff shortages which involves re-assigning staff to another unit in order to achieve equal staffing on each resident care unit.

In reviewing the staff that were working the days in September and October 2014 and the back-up plan, Inspector identified that the home deployed Plan B (one staff short), every day in September 30/30 days, and 31/31 days in October 2014. Plan C was deployed 7/30 days in September and 6/31 days in October 2014, (2 staff short). 1Plan D was deployed 3/30 days in September 2014 and

11/31 days in October 2014, (3 or more staff short in 24 hour period).

Inspector # 575 interviewed direct care staff throughout all resident care units of the home. Staff # 125, # 126, and # 109, from a resident care unit, told Inspector # 575 that during weekends the unit is usually 2-3 staff short and as a result staff do not take their breaks or come in early (on their own time) to get the Residents' care done. Staff # 109 stated that when they are short staffed, staff attempt to get all the Resident's care needs completed however, if they are unable to, bathing and shaving would get "put off" to the next day and Residents will have longer wait times for care. The staff members also stated that there is often not enough staff to assist with transferring Residents who require 2 staff therefore, Residents are required to wait for long periods of time.
Staff # 127, from one resident care unit, told Inspector that the unit is usually at least 1 staff short on a daily basis.
Staff # 128, from another resident care unit, stated that the unit is usually in Plan B (1 staff short) every other day and that weekends are worse.

Resident # 6520 told Inspector # 575, during an interview, that they normally do not have to call for assistance because they are independent however, on one specific day, they had to wait an hour after ringing the bell for assistance with their care needs. Inspector reviewed the call bell log for Resident # 6520. Inspector determined that on that day, the call bell was pressed at 6:23pm and was answered 47:11 minutes later. Review of the communication sheet identified that the home was 6 PSWs short staffed on evenings, and specifically 2 staff short (Plan C) on Resident # 6520's unit that evening. The Resident's care plan identified that Resident # 6520 required limited assistance at times for toileting, transfers and the Resident was encouraged to ring the call bell for assistance when needed.

Resident # 6506 told Inspector # 575 that they required staff assistance with toileting and a few weeks ago had to wait 30 minutes on the toilet after ringing the call bell waiting for staff to assist. Inspector reviewed progress notes and identified that, "Resident was very upset and expressed to PSW that they were left on the toilet today." This has happened before, according to the Resident. Inspector reviewed the Resident's washroom call bell log on the date of the incident and noted that the call bell was not answered for 15:38mins. The Resident's care plan identified that the Resident "requires extensive assistance of 1 staff for toileting and that the Resident can be left unattended and will ring the call bell for assistance when finished."

Inspector # 575 reviewed a Complaint Log filed by a family member for Resident #007. The family member, who approached Inspector # 575 during the inspection, stated that the home is constantly short staffed, often in Plan B, C or D (1 short, 2 short, 3 short respectively). The family member stated that Resident #007 is in a "split section" so when a worker does not show up for work, the caregiver is pulled to another section and Residents are added to their workload "on top" of their current assignment which means those Residents are divided up amongst the remaining sections. Resident # 007 has no consistency of care and has to wait a long time for assistance. Inspector reviewed the call bell log for the period of September 1-October 31, 2014. Inspector noted, on multiple occasions, Resident #007's call bell was not answered for over 10 minutes. Review of the most recent care plan identified that the Resident # 007 "requires extensive assistance of 2 staff with a mechanical lift for toileting on demand and for transfers from their bed to wheelchair and is able to use the call bell for assistance."

Inspector # 575 reviewed a Complaint Log filed by a family member for Resident #006. The family member identified that the Resident uses the call bell for assistance for their incontinent product to be changed, for repositioning, and for medications. The Resident advised the family member that they are required to wait for extended periods of time for staff assistance, especially on night shifts. The family member stated that the home is constantly short staffed and the Resident waits 20-30 minutes for assistance. Inspector reviewed the call bell log for the period of one week and noted that the Resident's call bell was routinely not answered in a timely fashion. The Resident's call bell was not answered for 10-15 minutes 35/335 activations and not answered for more than 15 minutes on 32/335 activations with 2 occasions exceeding 1 hour. Review of the Resident's most recent care plan identified that the resident required extensive assistance of 2 staff for repositioning in bed and incontinent product changes and required close monitoring to ensure the Resident's head of the bed remained elevated.

Inspector #575 reviewed the home's policy titled 'Nurse Call System' and noted the call system is available for the safety and convenience of residents and that staff are to respond to calls "in a rapid and courteous manner." The call bells are only de-activated after responding to the call.
During an interview with Staff # 101, Staff # 101 told Inspector that ideally call bells should be responded to within two (2) minutes.

A family member representing Resident # 6331 told Inspector #544, during a family interview, that on occasion, they have observed Resident # 6331's eyes crusted, food on their face, mucous in their nostrils and that, "it looks like staff have rushed through the resident's morning care and did not take extra care or time."

Staff #129 told Inspector # 575 that staff shortages are occur on a daily basis and that the Residents do not get the appropriate care because staff are rushed. The staff member indicated that they have no time to greet Residents and that they have noticed some Residents have had escalating behaviours due to feeling rushed. Staff # 129 further indicated that staff shortages are ultimately hurting the Residents by causing the Resident's to wait for long periods of time for assistance.

The home has displayed a pattern of insufficient staffing as determined by the above findings.

The licensee has failed to ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the Residents. (575)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 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 10th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Franca McMillan

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