Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 2, 3, 13, 14, 15, 16, 17, Sep 6, 7, 2012	2012_140158_0011	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Dietary Manager, the Dietitian, Registered staff, Personal Support Workers (PSWs), Quality Assurance Co-ordinator, maintenance staff, Activity aides, residents, families and visitors.

During the course of the inspection, the inspector(s) walked through resident home areas, observed staff to resident interactions and care, reviewed health care records,policies and procedures and staff education/training records. The following logs, S-0703-12, S-0903-12 were reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Continence Care and Bowel Management

Nutrition and Hydration

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 subsections:

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. It was noted by the Inspector that the smaller elevator in the home was not functioning on August 3/12 at 17:30hr leaving the home reduced to one elevator. On August 3/12, resident # 01 who was in the company of 4 other residents waiting for the elevator, was heard by the Inspector to use foul language and a loud angry voice to vocalize displeasure and agitation. The 4 other residents waiting at the elevator were observed by the Inspector to shake their heads and voice their displeasure with resident # 01 actions.
The health care record including the plan of care for resident # 01 was reviewed by the Inspector on August 3/12. The plan of care identified that resident # 01 is rude and becomes verbally/physically responsive when the resident's needs are not met. Interventions included; guide resident out of the area, sit and talk about the problem; encourage resident to walk away and talk with staff.
The Inspector observed that staff # 05, staff # 06 and staff # 07 were charting near the elevators and looked up when resident # 01 voice raised but did not attempt to redirect or manage the resident's agitated behaviour. Staff # 05 informed the Inspector that resident # 01 was "just acting their usual self". The care set out in the plan of care was not provided to resident # 01 as specified in the plan of care.[LTCHA 2007, S.O. 2007, c.8, s.6 (7)]
2. The health care record including the plan of care for resident # 02 was reviewed by the Inspector on August 3/12. Under the toileting section of the plan of care, it is identified that the resident is brought from bed to toilet to urinate before and after each meal and during the night upon request and prn (when necessary). The plan of care also identified that the resident is incontinent of urine and is frequently incontinent of stool requiring staff to provide pericare.
On August 2/12, the Inspector spoke to resident # 02 regarding nourishment and noted that the resident had a strong fecal odour at 11:20hr. The Inspector remained in close proximity to the resident's room and did not observe any staff enter the resident's room. The Inspector observed that the odour from the resident was stronger at 12:25hr.
When staff # 102 was administering medication at 12:30hr, the Inspector heard staff # 102 say to resident # 02 "Oh I thought the staff took care of you already." The Inspector then observed that staff # 102 spoke to staff # 101. Staff # 101 then entered the resident's room and stated to resident # 02 that "someone will come" before leaving the room at 12:40hr. The Inspector observed that staff # 103 provided toileting assistance and continence care to resident # 02 at 12:50hr.
The Inspector spoke with staff # 100, staff # 101, staff # 102 and staff # 103 on August 2/12 who all confirmed that the unit was short one staff member or working "Plan B" on August 2/12. It was identified by staff # 101 that the assignment section that resident # 02 is part of gains another resident when "Plan B" is activated. In addition, staff # 103 who was assigned to resident # 02 was off the unit for approximately an hour attending a care conference. Resident # 02 did not receive toileting assistance or continence care as specified in the plan of care.
The care set out in the resident's plan of care was not provided to resident # 02 as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, s. 6 (7)].
3. The Inspector reviewed the health care record including the plan of care for resident # 02 on August 2/12. The nutritional status component of the plan of care identified that the resident was at high nutritional risk. The plan of care was re-assessed by the home's dietitian and identified that the resident needs to consume over 1500 mls of fluids daily to maintain hydration. The resident fluid flow sheets from July 25/12 to August 2/12 were reviewed by the Inspector. The documentation identified that the resident did not receive the required amount of fluids to be adequately hydrated on July 25, 26, 28, 29, and July 31/12. The Inspector observed the nourishment pass on August 2 and 3/12 . The resident who was in their room was observed by the Inspector at 11:15hr to be sitting in the wheel chair with their eyes closed. Staff # 100 was observed to look into the resident's room and pass by without approaching the resident. The resident opened their eyes easily when the Inspector approached the resident a few minutes after Staff # 100 passed the room. The resident stated they required assistance to the bathroom. Staff # 100 stated that the unit staff know the residents who do not drink, especially in the morning so they (staff) don't usually disturb them. The care set out in the resident's plan of care was not provided to the resident as specified in the plan. [LTCHA 2007, S.O. 2007, c.8, 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 ensuring that the care set out in the plan of care is provided to the resident as specified in the plan., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following subsections:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care;
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard;
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency;
(d) a bedside table is provided for every resident;
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. A walk through of the home was conducted by the Inspector on August 2/12. Resident # 03 identified that the bed mattress was uncomfortable and lumpy when the Inspector questioned several residents about whether they were comfortable in their rooms.
The Inspector observed that the mattress in the room where resident # 03 resides was soft, lumpy with a hole at one end of the mattress. The licensee has not ensured that resident beds have a firm and comfortable mattress. [O Reg 79/10, s. 12 (2)(a)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following subsections:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The Inspector reviewed the health care record including the plan of care for resident # 02 on August 3/12 in which it is identified that resident # 02 has a history of Urinary Tract Infections (UTI) and had been admitted to hospital with a severe UTI. Subsequent to returning from hospital, the July/12 progress notes identified that on the night shift, the resident's urine was observed to be dark in colour and foul smelling. The next shift did document their assessment of resident # 02 urinary status however there was no further reference in the progress notes identifying that resident # 02 was being monitored for signs and symptoms of a UTI. There was no documentation in the 24-hr report book identifying that the monitoring of the resident's urinary status was to be done. The Inspector reviewed the doctor's book and there was no documentation identifying that the resident had dark foul smelling urine. The home does have a policy # 05-14 identifying the procedures to implement if a resident is suspected as having a urinary tract infection. As per policy, the PSW staff did report the signs of infection to the Registered staff however the documentation identified that only one shift monitored the urinary status of resident # 02. There was no further assessment and monitoring of resident # 02 or notification to the physician as identified in the policy documented.
The Inspector reviewed resident # 02 fluid flow sheet documentation for the period of July 25-July 31/12. Resident # 02 did not receive the amount of fluids required as assessed by the dietitian. Code 97 or 98 as documented on the July 1-31/12 fluid flow sheet was consistently used for the nourishment pass. Staff # 100 stated to the Inspector that the two above codes are used to signify the resident's refusal of the nourishment but the Dietary Manager confirmed on August 7/12 that 97 is the code for 'not applicable" and 98 is the code for "refusals".
On August 2 and August 3/12, the Inspector observed that staff did not offer or provide resident # 02 with anything to drink during the nourishment pass however code 98 (refusal) was documented on the flow sheet when the Inspector checked it on August 7/12.
Monitoring of an infection, implementation of strategies to prevent or reduce an infection including offering fluids during the nourishment pass were not done for resident # 02. The home did not ensure that residents are not neglected by the staff. [LTCHA 2007, S.O. 2007, c.8, s.19 (1)]

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 ensuring that all residents who have a urinary tract infection or have a history of such are monitored, provided with strategies to reduce or prevent urinary tract infections and that all residents are offered and provided fluids at nourishment pass according to their assessed need, to be implemented voluntarily.

Issued on this 7th day of September, 2012

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