Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 24, 2014	2014_283544_0017	S-000199-14	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

FRANCA MCMILLAN (544)

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): June 23, 24, 25, 2014 related to

Log # S-000199-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Directors of Care, (ADOCs), Risk Management Co-ordinator, Registered Staff, Personal Support Workers (PSWs), Residents and Families.

During the course of the inspection, the inspector(s) observed daily the delivery of care and services to the residents, staff to resident interactions, resident's response to pain, reviewed resident health care records, progress notes, doctors orders, treatment records, Skin and Wound Care Program and the staff education/training and staff attendance records in regards to this program.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Skin and Wound Care

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. (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 :

Inspector # 544 reviewed the doctor's orders, progress notes and treatment administration record (TAR), and found that Resident # 001 was admitted to the home with a wound that had developed while the Resident was an inpatient in the hospital. Inspector # 544 reviewed the care plan for Resident # 001 and identified that the admission, the revised and the current wound care interventions were not identified in the care plan. Resident # 001's care plan had not been revised even though there had been changes to the resident's care needs.

Staff # 101 and Staff # 105 confirmed that the resident's care plan was initiated on admission and that the care plan had not been revised until later.

A). Inspector # 544 reviewed Resident # 001's admission assessment by Staff # 104 who identified that the Resident required a special diet. Staff # 104 then re-assessed the Resident and ordered extra nutrients to their diet.

These nutritional changes to the Resident's diet were not addressed in the current care plan.

B). Inspector # 544 identified the wound was not staged in the care plan
This was confirmed by Staff # 105, # 106 and Staff # 107.

C). Staff # 105, # 106 and # 107 also confirmed that it was not identified or written in the Resident's care plan what type of dressing interventions were in place for the wound, what product was to be used for the dressing changes and how often the dressing changes were to occur.

D). Inspector # 544 identified that there was no focus, goals or interventions in the care plan in regards to Resident # 001's pain issues that the Resident was experiencing, according to the progress notes.
This was confirmed by Staff # 106 and Staff # 105.

E). Inspector # 544 identified that Resident # 001's care plan did not identify the need for their blood glucose levels to be monitored, as ordered by the physician.
Staff # 106 confirmed that the blood glucose level monitoring was not in the care plan.

The licensee did not ensure that there is a written plan of care for Resident # 001 that sets out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Resident # 001 was admitted to the home with a wound.
Inspector # 544 reviewed Resident # 001's care plan and identified that the care plan had not been revised even though there were changes in the Resident's condition, needs and doctor's orders.

A). The Wound Care Protocol (WCP) regime was changed in June 2014. The plan of care did not identify what product was to be used on the wound, how many times the dressing was to be changed nor did it address the extra outer cover dressing that was ordered.

B). In May 2014, the physician had ordered wound care protocol for a new wound that had developed. In June 2014, the physician ordered wound care protocol for a another new wound that developed.

The care plan had not been revised to address or reflect the care needs for these new wounds and the changes in regards to Resident # 001's new skin and wound developments.

C). The care plan does not identify the focus, goals or outcomes in regards to the pain

that Resident # 001 was experiencing.

Staff # 105 # 106 and # 107 confirmed that Resident # 001's care plan had not been reviewed or revised when Resident # 001's care needs changed.

The licensee failed to ensure that Resident # 001's plan of care was reviewed and revised when Resident # 001's care needs changed. [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 there is a written plan of care for Resident # 001 that sets out the planned care for the resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to Resident and that Resident # 001's plan of care is reviewed and revised when the care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

Findings/Faits saillants :

1. Inspector # 544 reviewed the Patient Transfer Record from the hospital when Resident # 001 was discharged from the hospital to the long-term care home. In the Patient Transfer Record, it was written that Resident # 001's blood glucose levels were done daily.
This was not transcribed to the 24 hour care plan or the electronic treatment record.

Staff # 105 confirmed that Resident # 001's blood glucose levels should have been done at least once a day as per the Patient Transfer Sheet. Staff # 105, # 106 and # 107 confirmed that Registered Staff are to use the orders on the transfer sheet and

then have the orders verified with the physician on admission.

The Resident had their blood glucose level checked only on admission. No further blood glucose levels could be found documented on the health care record.
It was confirmed by Staff # 106 that no other blood glucose levels were completed until a new doctor's order was received several weeks later.

The Resident's 24 hour care plan did not identify that blood glucose levels were to be taken.

2. In the Resident's Patient Transfer Record, Inspector # 544 identified that there was a treatment regime for the wound.
This was not identified on the 24 hour care plan.

3. On admission, the home initiated Wound Care Protocol (WCP) as per the doctor's order for the wound dressing.

Inspector # 544 identified that there was once again no dressing regime on the care plan for Resident # 001.

It was not identified or written in the 24 hour care plan what type of dressing interventions were in place for the wound dressing changes, what product was to be used and how often the dressing changes were to be done.

4. Inspector # 544 reviewed all the progress notes in the health care record since Resident # 001's admission.
Resident # 001's health care record indicated that their admission assessments were completed as per the admission checklist however, the dressing to their wound was not removed on their admission day and therefore, the head to toe assessment was incomplete. The Registered Staff could not verify the staging of the wound nor the condition of the Resident's wound.

The 24 hour care plan was incomplete and the staging of the wound was not clear in the 24 hour care plan.

Staff # 105 repeated to the Inspector that Registered Staff are to use the orders on the Patient Transfer Record and then have the orders verified, reviewed or changed by the physician on admission.

The licensee failed to ensure that the 24 hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. [s. 24. (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 that a 24 hour admission care plan is developed for the resident and communicated to direct care staff within 24 hours of the resident's admission to the home. The care plan must include customary routines and skin condition including interventions, to be implemented voluntarily.

Issued on this 29th day of July, 2014

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