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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 24, 2015	2015_328571_0010	O-002662-15	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 HALIBURTON
167 PARK STREET P.O. BOX 780 HALIBURTON ON K0M 1S0

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

PATRICIA MATA (571), CHANTAL LAFRENIERE (194), DENISE BROWN (626), JULIET MANDERSON-GRAY (607)

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): September 28, 29, 30, October 1, 2, 5, 6, 7, 8, and 9, 2015.

During this inspection, Complaint Log #O-002669-15 and Complaint Log #O-002818 -15 were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Nursing Co-ordinator, RAI-MDS Co-ordinator, Registered Nurses (Rn), Registered Practical Nurses (Rpn), Personal Support Workers (Psw), Environmental Manager, Program Manager, Dietary Manager, Recreation Staff, residents and family members/power of attorney.
In addition, the following was reviewed at: clinical records, administrative records, meeting minutes, program calendars, menus, and posted information.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

5 WN(s)
2 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. O. Reg. 79/10, s. 48.(1)1., requires that every licensee of a long-term care home shall ensure that a falls prevention and management program to reduce the incidence of falls and the risk of injury is developed and implemented in the home.

The licensee has failed to ensure that their falls policy was complied with for resident #024 by ensuring the resident was clearly identified as a high risk for falls.

Resident #024 is identified as being a high risk for falls on the current care plan and had two falls in a specified month.

A review of the licensee's Falls policy RESI-09-02-01 revised November 2011 states that each home is to have a flagging system to clearly identify to all staff which residents are at high risk for falls.

RN #101 indicated in an interview that when a resident is identified to be a high risk for falls, a star is place on the resident's name card on the wall outside their room and on a name card on the foot board of the identified resident. This is the responsibility of all registered staff.

PSW #110 indicated in an interview that he/she assumed resident #024 was a high risk for falls due to the fact the resident has an unsteady gait and grabs on to the PSW's wrists during toileting as the resident is afraid of falling.

A falling star was noted by Inspector #571 to be absent from resident #24's name card outside the resident's room and on the foot board of the bed. Therefore, the home failed to follow their falls policy, specifically regarding how a resident is to be identified as a high risk for falls. [s. 8. (1) (a),s. 8. (1) (b)]

2. O. Reg. 79/10, s. 114.(2), requires that every licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of drugs used in the home.

The licensee has failed to ensure their policy for Narcotics and Controlled drugs was complied with.

A review of the home's policy titled Narcotics and Controlled drugs, policy #11-20, dated December 2011 revealed that following the administration of the narcotics, the Registered Staff will record the administration of the medication on the medication administration record and also on the narcotic counting form as per the pharmacy policy and procedure.

Inspector #607 observed on a specified date and time, that the individual narcotic and controlled drug administration record was not signed off at the time of administration for the following residents for a specified date:
- narcotic for resident #042, specified dose
- narcotic for resident #007, specified doses
- narcotic for resident #010, specified dose
- narcotic for resident # 055, specified doses
- narcotic for resident # 054, specified dose
- narcotic for resident #011, specified dose

An interview with RPN #120 revealed that he/she is aware that the individual narcotic count sheet should be signed for at the time administration, but because he/she is so busy at medication pass he/she only signs the electronic medication administration record (eMAR) and does not sign the narcotic and controlled drug administration record for each resident until the end of his/her shift.

Interviews with RN #101 and the DOC confirmed that the homes policy and expectation is that Registered Nursing staff sign in the resident individual narcotic sheet and eMAR that a narcotic has been administered, at the time of administration. [s. 8. (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 for ensuring that the licensee's policies for falls and narcotics and controlled drugs are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident had his or her personal items labelled.

During the inspection on September 28, 29 and 30, 2015, inspectors #571, #194, #607 noted the following resident personal items not labelled in 11 shared bathrooms:
-a bar of soap, three tooth brushes, one comb, one urinal
-two toothbrushes
-four toothbrushes
-two toothbrushes, one roll on deodorant
-three toothbrushes, one toothpaste
-two toothbrushes, one brush
-two toothbrushes, one bar of soap, one urinal, one deodorant
-three toothbrushes
-four toothbrushes
-one toothbrush, one brush
-four toothbrushes, one toothpaste, stored on the back of the toilet

In an interview with inspector #194, resident #031, indicated that he/she brushes their own teeth but does not know which toothbrush is his/hers in the bathroom.

RN #101 indicated in an interview with inspector #194, that all personal items are supposed to be labelled by the PSWs. [s. 37. (1) (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 for ensuring that each resident has his or her personal items labelled, to be implemented voluntarily.

WN #3: 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 clear direction is provided in the written plan of care for resident #034's responsive behaviours.

Resident #034 is wheelchair dependent.

During interview with PSW #111 and #110 the responsive behaviours for resident #034 were described as being resistive to care. PSW's indicated that the resident would be able to verbally identify when the resident did not want care to be provided and that staff, would leave the resident alone and re-approach at a later time. PSW's also indicated that if two staff were required only one staff would provide direction to reduce the resident's confusion.

During an interview the Behavioural Support Ontario RPN #108 indicated that resident #034 would be resistive to care during a specific time when provided assistance to bed.

Review of the progress notes for the specified period related to responsive behaviours was completed. Numerous entries documenting resident #034 resistance to am/pm care and continence care are documented.

The current plan of care was reviewed and indicated that Resident #034 exhibits resistive behaviour related to dressing and to provide care slowly when the resident is resistive.

The written plan of care for Resident #034 does not provide clear direction for staff related to the resident's resistive behaviours and physical aggression towards staff during care, use of foul language and refusing to go to bed. [s. 6. (1) (c)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that are meals served course by course unless otherwise indicated by the resident or the resident's assessed needs

During the observation of the lunch meal on a specified date the following was observed by the inspector:

-Resident #009 was provided their dessert and the main course was not removed from the table.
-resident #005 was provided their dessert and the main course was not removed from the table
-resident #006 was provided their dessert while still eating the main course
-resident #041 was provided their dessert while still eating the main course

During the observation of the lunch meal on another specified date the following was observed by the inspector:

-Resident #043 was provided their dessert and main course was still on the table.
-Resident #044 was provided their dessert while still eating the main course.

An interview with the FSM was conducted by the inspector and it was explained that the prevailing practice at the home and her expectation was that the meal service was to be completed course by course. [s. 73. (1) 8.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

During observation of bathroom for resident #036 it was noted that the grab bar for the raised toilet seat that the resident uses was loose. Review of the plan of care for Resident #036 indicates that the resident completes toileting unassisted and is at risk for falls related to unsteady gait. Resident #036 also has cognitive impairment.

During an interview with the ESM, Inspector #194 was informed that staff are to enter all repairs required in the maintenance book located at the nursing station. Review of the maintenance book was completed with ESM and no entry related to loose grab bar was noted. ESM indicated that the housekeeping staff will verbally inform him as well if they notice equipment that needed repair. During interview with housekeeping staff #109 it was indicated that if equipment was noted to require repair a verbal message would be provided to the ESM.

The home's procedure of documenting required repairs in the maintenance book or verbally informing the ESM was not implemented related to the grab bar in room #21 placing resident #036 at potential risk for falls. [s. 90. (2) (d)]

Issued on this 24th day of November, 2015

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

Original report signed by the inspector.