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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| May 22, 2015 | 2015_327570_0014 | O-001962-15 | 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 KAWARTHA LAKES
125 Colborne Street East LINDSAY ON K0L 2V0

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

SAMI JAROUR (570), CAROLINE TOMPKINS (166), RUZICA SUBOTIC-HOWELL (548)

## 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): May 5 - May 8, 2015 and May 11 - May 14, 2015**

**Critical Incident Logs O-000483-14 and O-000484-14 were also inspected concurrently.**

**During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), RAI Coordinator/Educator, Physiotherapist, Physiotherapy Assistant, Registered Nurses (RN), Registered Practical Nurses(RPN), Personal Support Workers (PSW), Residents, Family members, and Residents' Council President.**

**During the course of the inspection, the inspector(s) toured the home, observed dining service, observed medication pass, reviewed residents' health care records, reviewed Residents' Council minutes, and reviewed the homes policies on physical restraints.**

**The following Inspection Protocols were used during this inspection:**

**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Recreation and Social Activities**
**Residents' Council**
**Responsive Behaviours**
**Skin and Wound Care**
**Sufficient Staffing**

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

- **4 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**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 :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Related to Resident #32

On 3 specified dates, Resident #32 was observed sitting in a tilt mobility aid with tilting feature engaged.

During an interview, RPN #101 indicated that Resident #32 was provided with a tilt mobility aid from the home about two months ago. It is not known who provided the tilt mobility aid to the resident; the tilt mobility aid is used for Resident #32 due to leaning forward. RPN #101 indicated that the expectation is that the resident is assessed by physiotherapy staff before mobility aid is provided to the resident.

During an interview, Physiotherapist indicated that Resident #32 is not currently receiving physiotherapy and no referral for Resident #32 was received for tilt mobility aid assessment.

Related to Resident #39

On 3 specified dates, Resident #39 was observed sitting in a tilt mobility aid with tilting feature engaged.

Review of clinical records for Resident #39 indicated that the resident's regular mobility aid was replaced with a tilt mobility aid on an earlier date by the physiotherapist.

Interviews with RPN #101 and PSW #108 indicated that the resident is currently using a tilt mobility aid and the resident is totally dependent mobility. The resident is tilted for positioning due to leaning forward and sliding out.

Interview with Physiotherapist indicated that Resident #39 did not have a change in condition and the resident should not be tilted. The resident was provided with a tilt mobility aid for positioning to promote proper seating. The physiotherapist indicated that this was communicated to unit staff that Resident #39 did not have a change in condition and the resident does not need to be tilted.

Staff interviews and record review for Residents #32 and #39 indicate no collaboration among staff and others involved in the care of both residents in relation to use of tilt mobility aid. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan was no longer necessary.

Related to Resident #32

On 3 specified dates, Resident #32 was observed sitting in a tilt mobility aid with tilting feature engaged.

Review of clinical records for Resident #32 indicated no documented evidence of any assessments related to the use of a tilt mobility aid.

Review of Resident #32's current plan of care indicated under "Locomotion" indicated that the resident requires extensive assistance to move between locations by walking with walker or using mobility aid.

Review of current electronic and printed plan of care accessible to PSW staff indicated that Resident #32:
- Requires two staff extensive assist for transfers.
- Ambulates with limited assistance. Physical support or assistance required on as needed basis.

Interviews with RPN #101 and PSW #108 indicated that the resident is currently unable to walk and using a tilt mobility aid with total dependence mobility. The resident is tilted for positioning due to leaning forward. The SARA (sit to stand) lift is used to assist with transfers.

RPN #101 confirmed that the plan of care for Resident #32 was not updated when the resident received a tilt mobility aid and when the resident's transfer and mobility status has changed.

Related to Resident #39

On 3 specified dates, Resident #39 was observed sitting in a tilt mobility aid with tilting feature engaged.

Review of clinical records for Resident #39 indicated that the resident's regular mobility aid was replaced with a tilt mobility aid on an earlier date by the physiotherapist.

Review of Resident #39's current plan of care indicated under "Locomotion" that the resident requires extensive assistance to move between locations by walking with walker or using mobility aid.

Review of current electronic and printed plan of care, for Resident #39, accessible to PSW staff indicated that the plan of care was not updated to reflect the use of tilt mobility aid including repositioning of the resident and degree of tilt required.

Interviews with RPN #101 and PSW #108 indicated that the resident is currently using a tilt mobility aid and the resident is totally dependent in mobility. The resident is tilted for positioning due to leaning forward and sliding out.

RPN #101 confirmed that plan of care for Resident #39 was not updated when the resident received a tilt mobility aid.

The plan of care was not revised for both Residents #32 and #39 to identify the use of tilt mobility aid including the frequency and degree of tilting required. Resident #32's plan of care was not revised when the care needs related to transfer and mobility status for the resident changed. [s. 6. (10) (b)]

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.**

**Specifically failed to comply with the following:**

**s. 29. (1) Every licensee of a long-term care home,**
**(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).**
**(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to comply with LTCHA, 2007 s. 29(1)(b) when the policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations was not complied with.

The licensee's policy "Physical Restraints, policy reference # RESI-10-01-10 dated November 2012" identifies:
Approved Physical Restraints: the following physical devices may be used within Extendicare homes after a thorough evaluation of all alternatives and based on all the requirements of documentation as outlined in this policy being met:
- Front Closing Seatbelt;
- Tilt feature, when engaged, on a wheelchair or Geriatric chair;
- Lap Boards/Trays/table tops on wheelchair/geri chair;
- Bed Side Rails.

Residents #32 and #39 were observed on 3 specified dates sitting in tilt mobility aid with tilt feature engaged.

Interview with RPN #101 and PSW #108 indicated that Resident #32 and Resident #39 are using tilt mobility aid. Resident #32's mobility aid is tilted to prevent leaning forward and Resident #39's mobility aid is tilted for positioning due to leaning forward and sliding out. RPN #101 and PSW #108 indicated that Residents #32 and #39 do not have any restraints in use.

Interview with DOC indicated that for both Resident #32 and #39 the tilt mobility aid is not considered a restraint. Resident #32 is able to get out of the tilt mobility aid when tilted. Resident #39 is not able to get out from the tilt mobility aid regardless tilted or not.

During the interview the DOC confirmed that the licensee's policy indicating that tilt feature, when engaged, on a tilt mobility aid is considered a physical restraint was not followed. [s. 29. (1) (b)]

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.

On 3 specified dates, Resident #32 was observed sitting in a tilt mobility aid with tilting feature engaged.

During an interview, RPN #101 indicated that Resident #32 was provided with a tilt mobility aid from the home about two months ago. It is not known who provided the tilt mobility aid to the resident. The tilt mobility aid is used for Resident #32 due to leaning forward. RPN #101 indicated that the expectation is that the resident is assessed by physiotherapy staff before mobility aid is provided to the resident.

During an interview, Physiotherapist indicated that Resident #32 is not receiving physiotherapy and no referral was received to assess Resident #32 for a tilt mobility aid.

On a specified date and time, Inspector #570 observed Resident #32 in own room with Physiotherapist present. The resident was sitting in tilt mobility aid and was in a tilted position; both resident's feet were not reaching the foot rests; Physiotherapist indicated the tilt mobility aid is not a proper fit for the resident as the resident requires more depth in seating and both foot rests needed to be adjusted.

Using an improper fit mobility aid is likely to cause discomfort to the resident and increases the risk of sliding from the mobility aid putting the resident at risk of injury. [s. 30. (1) 2.]

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).**

**Findings/Faits saillants :**

1. On a specified date, the MOHLTC received a Critical Incident Report that indicated Resident #5 was not provided a between-meal beverage.

Resident #5 is diagnosed with several co-morbidities and cognitive loss that affects the resident’s ability to recognize thirst. Upon review of the plan of care (that was in effect at time of incident), interventions specified that the consumption of fluids at meals, snack times, and medication passes be encouraged and that the resident be encouraged to take fluids throughout the day.

Review of the home’s investigation notes and an interview with the DOC indicated that Resident #5 was not provided fluids on two specific occasions.

During an interview the DOC confirmed that PSW #120 admitted to not offering or providing Resident #5 any "between-meal beverage" in the afternoon during one week of an identified month. The DOC indicated that PSW #120 did not provide the between-meal beverage to Resident #5 as the resident “would make a mess or throw the drink on the floor”.

It is noted on the Resident Daily Food and Fluid Intake document of identified dates of the week of the incident that the resident either refused afternoon nourishment or was sleeping for afternoon nourishment.

As such, the licensee failed to ensure Resident #5 was offered at a minimum a between-meal beverage in the afternoon. [s. 71. (3) (b)]

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**Issued on this 22nd day of May, 2015**

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

**Original report signed by the inspector.**