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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 15, 2014	2014_206115_0016	L-001332-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE LONDON
860 WATERLOO STREET, LONDON, ON, N6A-3W6

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

TERRI DALY (115), INA REYNOLDS (524), JULIE LAMPMAN (522)

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): October 6, 7, 8, 9, & 10, 2014

During the course of the inspection, the inspector(s) spoke with spoke with the Administrator, the Acting Director of Care, the Dietary Manager, the Program Manager, the Support Services Manager, two Registered Nurses, six Registered Practical Nurses, the RAI Coordinator, six Personal Support Workers, one Dietary Aide, five family members, and forty-two residents.

During the course of the inspection, the inspector(s) conducted a tour of the resident home areas and common areas, observed a meal service, observed residents and care provided to them. Medication administration and storage areas were observed. Reviewed clinical records of identified residents, policies and procedures, meeting minutes, and other pertinent records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council

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. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that advice related to concerns and recommendations from Resident Council are responded to in writing within 10 days.

A review of the Resident Council/Dining Room Committee meeting minutes from the January 30, 2014 and April 24, 2014 meetings revealed that concerns had been brought forward with no evidence of written follow up within 10 days.

A discussion with management reveals that these issues were not responded to appropriately in writing within 10 days.

Management indicate it is the expectation of the home that all advice related to concerns or recommendations from Residents' Council should be responded to in writing within 10 days. [s. 57. (2)]

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 any advice related to concerns and recommendations from Resident Council is responded to in writing within 10 days, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that advice related to concerns or recommendations from Family Council is responded to in writing within 10 days.

A review of the Family Council meeting minutes from the February 4, 2013 meeting revealed concerns brought forward by two family members.
There is no evidence that these issues were followed up in writing within 10 days.

An interview with a Family Council member revealed that most concerns are immediately responded to at the meeting by invited management who are attending. However, confirms that perhaps not all issues have written follow up in the minutes or in writing within 10 days as required.

Management acknowledge that all advice related to concerns and recommendations from Family Council should be responded to in writing within 10 days if not already followed up at the meeting. [s. 60. (2)]

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 any advice related to concerns and recommendations from Family Council is responded to in writing within 10 days, to be implemented voluntarily.

WN #3: 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. 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.

An interview with a registered staff member revealed that a controlled substance is stored in the fridge in the locked medication room on the first floor.

Observation of the fridge with the staff member revealed that the controlled substance is not double locked.

An interview with the management confirmed that all controlled substances are to be double locked. [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 all 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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

An interview with a manager revealed that there was a medication incident involving a resident whereby the resident was given a medication that was not in accordance with the directions for use by the prescriber.
There were no adverse effects to the resident.

A review of the resident electronic medication administration record (EMAR) revealed the order was transcribed incorrectly.

An interview with the manager confirmed the expectation that the medication should have been administered to the resident in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

2. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

An interview with a resident revealed the resident keeps medication at the bedside and self administers the medication as necessary.

An interview with the registered staff revealed that staff were unaware that the resident was self administering medication. Review of the physician's orders revealed the resident did not have an order for self administration of the medication.

An interview with management confirmed the expectation that a resident does not self administer medication unless the medication has been approved by the physician. [s. 131. (5)]

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 administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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 the plan of care provides clear direction to the staff and others who provide direct care to the resident.

A record review of the plan of care on Point Click Care for a resident revealed the specific individualized interventions.

A staff interview with a Personal Support Worker revealed that these interventions were no longer current.
Management confirmed that the interventions documented in the resident's plan of care were not current and stated it is the home's expectation that the plan of care provide clear direction to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

WN #6: 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. The licensee has failed to ensure that the home is maintained in a good state of repair.

Observation of resident home areas during a tour on October 6, 2014 revealed the following:

On the first floor across from room 109 plugs in the wall had not been not repaired.

On the second floor there were numerous door frames with paint chips and numerous room doors with scrapes along the bottom. The floor in front of elevator had numerous marks and scuffs.
The walls across from room 200 and room 206 had unrepaired holes in the wall.

In the third floor dining room the radiator was coming away from the wall.

Observation of resident rooms and bathrooms on October 9, 10 and 11, 2014 revealed:
Room 225- bathroom door had black scuffs and chipped paint. The resident room wall was damaged above the baseboard.
Room 243 -wall to left of room door was gouged and the paint was scraped off.
Room 101- bathroom door frame had significant paint chips around the bottom, black scuffed areas on the bathroom door.
Room 112 – bathroom door frame had paint chips.
Room 330 - scrapes on bathroom door; corrosion noted in bathroom sink at drain; bolt cover missing from toilet; rust noted around toilet base.
Room 118 –the privacy curtain in between beds was torn at the top.
Room 109 – the bathroom door frame had paint chips and some wall damage.
Room 309B - corrosion noted in bathroom sink at drain hole; bolt cap cover missing

from toilet.
Room 203 -inside of the bathroom door along the bottom was scraped; bottom of wall alongside door paint was scraped off.
Room 104-paint chips and wall damage noted in and around bathroom door and door frame, including wall outside bathroom by window and the wall heater.
Room 329A – paint chips observed on entrance door; closet door not closing; scrapes/chips on closet door; Bathroom had black scrapes and paint chips and the wall was damaged; hole in wall not filled or repaired.
Room 232 -inside of bathroom door was scraped along the bottom.
Room 330 - scrapings on bathroom door; corrosion noted in bathroom sink at drain; bolt cover missing from toilet; rust noted around toilet base.
Room 223 -wall above paper towel dispenser had holes repaired but they were not sanded or painted; the trim around the base of the wall was coming away.
Room 200 -inside of bathroom door had scrapes along the bottom; wall beside door had paint scraped off along the bottom.
Room 228 -scrapes across wall in bathroom; scrapes across bottom of bathroom door.
Room 109 -resident bathroom door and door frame has significant paint chips and scuff marks.
Room 227 -bathroom door has paint scraped off the bottom, wall alongside room door has gouges along the bottom.
Room 225-inside of bathroom door was scraped along the bottom; wall beside door had paint scraped off along the bottom.
Room 243 -wall to left of room door was gouged and the paint was scraped off.
Room 208 -inside of bathroom door had scrapes along the bottom.

An interview with the Support Services Manager confirmed the need for repairs. The Support Services Manager and Administrator confirmed the expectation that the home is maintained in a good state of repair. [s. 15. (2) (c)]

Issued on this 16th day of October, 2014

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