Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 3, 2020	2020_824765_0015	004379-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Timmins
15 Hollinger Lane Box 817 Schumacher ON P0N 1G0

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

HILARY ROCK (765), KEARA CRONIN (759)

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): August 10 - 14, 2020.

The following intake was completed in this Complaint inspection:
one intake related to a complaint regarding various concerns relating to a resident's provision of care.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Assessment Instrument (RAI) manager, Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

The inspector(s) also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents, policies and procedures.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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	Légende 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that different approaches were considered in the revision of the plan of care when the care set out in the plan had not been effective.

A complaint was submitted to the Director that outlined various concerns relating to a resident's provision of care.

Inspector #765 reviewed progress notes on Point Click Care (PCC) regarding resident #001's multiple falls within a specified time frame; resident was found on the floor for each of the falls.

Inspector #765 reviewed resident #001's post fall assessments for their specified falls which indicated the causes for the falls.

Inspector #765 reviewed resident #001's care plan at the time of their multiple falls and it advised staff of an intervention. Inspector #765 could not identify any interventions added as a result of their multiple falls.

Inspector #765 reviewed progress notes on PCC and could not identify any different approaches considered to help prevent falls.

RPN #110 indicated that a specified falls intervention was the best system for resident #001. RPN #110 stated that the specified falls intervention should have been considered at the time of the multiple falls for resident #001's safety.

During separate interviews, RPN #107 and RPN #110 were unable to identify what different approaches were considered for falls prevention regarding resident #001's multiple falls.

Inspector #765 interviewed RN #118 who reviewed PCC for resident #001's multiple falls and stated that no different approaches were considered and they should have been. RN #118 also indicated that they should have considered a specified falls intervention.

Inspector #765 interviewed the DOC who reviewed PCC for resident #001's multiple falls and stated that the resident now had a specified falls intervention. The DOC reviewed their high risk fall meeting documentation but indicated that their last documented meeting was before resident #001's multiple falls. The DOC stated that they had no documentation that different approaches were considered. [s. 6. (11) (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 different approaches are considered in the revision of the plan of care when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that where this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the licensee was required to ensure that the policy or procedure was complied with.

In accordance with Ontario Regulations (O. Reg.) section 49(2), the licensee was required to ensure that when a resident has fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Specifically, staff did not comply with the licensee's policy titled "Falls Prevention and Management Program."

A complaint was submitted to the Director that outlined various concerns relating to a

resident’s provision of care.

a) Inspector #765 reviewed resident #001’s progress notes in PCC that indicated resident #001 was found lying on the floor.

Inspector #765 reviewed resident #001’s post fall assessment from the fall, that indicated clinical monitoring for head injury was not required; however, it stated their fall was unwitnessed. The Inspector reviewed resident #001’s assessments and could not identify a clinical monitoring record for their fall that occurred on the specified date.

Inspector #765 reviewed the licensee’s fall policy titled "Falls Prevention and Management Program," which indicated that if a resident hit their head or was suspected of hitting head (eg unwitnessed fall) staff were to complete the clinical monitoring record. The clinical monitoring record indicated to monitor specified areas every hour for four hours then every eight hours for 72 hours.

In separate interviews, RPN #107 and RN #118 stated to Inspector #765 that staff are expected to start the clinical monitoring record immediately when the resident hit their head or had an unwitnessed fall.

Inspector #765 interviewed the DOC who confirmed that resident #001’s clinical monitoring record was not completed. The DOC indicated that their policy stated to complete a clinical monitoring record for unwitnessed falls and they expect their staff to follow the policy.

b) Inspector #765 reviewed resident #005’s progress notes in PCC and identified they fell on a specified date.

Inspector #765 reviewed resident #005’s assessments from the specified fall, and could not identify a clinical monitoring record. Inspector #765 reviewed the risk management which indicated that resident #005’s specified fall was unwitnessed.

Inspector #765 interviewed RPN #120, who completed the post fall assessment, and they confirmed that resident #005's fall was unwitnessed.

During an interview with Inspector #765, the DOC stated that resident #005 was confused post fall and they did not have a clinical monitoring record completed for their fall on the specified date. The DOC indicated that their policy stated to complete a clinical

monitoring record for unwitnessed falls and they expect their staff to follow the policy. [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 to ensure that where this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy or procedure, the licensee is required to ensure that the policy or procedure is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004, #006 and #001, who all exhibited altered skin integrity, were assessed by a RD who was a member of the staff of the home.

A complaint was submitted to the Director that outlined various concerns relating to a resident's provision of care.

Inspector #759 reviewed resident #004's electronic health records and identified that resident #004 had areas of altered skin integrity that required wound care from a Registered Staff member.

Both inspectors reviewed the home's policy titled, "Skin and Wound Program: Wound Care Management," which indicated that staff were to complete a referral to the RD for all residents who exhibited altered skin integrity.

Inspector #759 reviewed completed wound care assessments from a specified time frame for resident #004 and identified a number of initial wound assessments that were completed for new areas of altered skin integrity. The assessment contained a section that outlined referrals that were made, and Inspector #759 noted that no referrals were made to the RD on multiple dates.

During an interview, Inspector #759 reviewed the dates of the new areas of altered skin integrity for resident #004 with the DOC. The DOC indicated that as per the home's policy, a referral to the RD was required with every new wound.

Inspector #759 interviewed the RD, and they indicated that they did not receive referrals for every new area of altered skin integrity. [s. 50. (2) (b) (iii)]

2. Inspector #765 reviewed resident #006's electronic health records and identified that resident #006 had an area of altered skin integrity.

Inspector #765 reviewed resident #006's wound care assessment from a specified date, that was completed for a new area of altered skin integrity. The assessment contained a section that outlined referrals that were made, and Inspector #765 noticed that no referrals were made to the RD.

During an interview with Inspector #765, RPN #107 stated that registered staff did not send referrals to the RD anymore; they were to send a referral to the Wound Champion who then were to send referrals to the RD.

Inspector #759 interviewed the RD who indicated that they did not receive referrals for every new area of altered skin integrity.

During an interview, Inspector #765 reviewed the date of the new area of altered skin integrity for resident #006 with the DOC. The DOC indicated that as per the home's policy, a referral to the RD was required with every new incident of altered skin integrity. [s. 50. (2) (b) (iii)]

3. Inspector #765 reviewed resident #001's altered skin integrity assessments and identified that resident #001 had multiple areas of altered skin integrity.

Inspector #765 reviewed resident #001's wound care assessments which contained multiple skin concerns since different specified dates. The assessment contained a section that outlined referrals that were made, and Inspector #765 noticed that no referrals were made to the RD.

Inspector #759 interviewed the RD who indicated that they did not receive referrals for every new area of altered skin integrity.

During an interview, Inspector #765 reviewed the date of the new areas of altered skin integrity for resident #001 with the DOC. The DOC indicated that as per the home's policy, a referral to the RD was required with every new incident of altered skin integrity. [s. 50. (2) (b) (iii)]

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 resident #001, #004, #006, and all other residents who exhibit altered skin integrity, are assessed by a RD who is a member of the staff of the home, to be implemented voluntarily.

WN #4: 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 drugs were stored in a medication cart that was secure and locked.

A complaint was submitted to the Director regarding various concerns relating to a resident's provision of care.

During the inspection, Inspector #765 observed a medication cart that was left unlocked in the dining room on a specified unit with multiple residents in the area; there were no staff members present.

Inspector #765 interviewed RPN #107 who confirmed that there were items that were harmful to residents in the medication cart and that they left it unlocked and unattended. RPN #107 stated that the medication cart should have been locked.

Inspector #765 interviewed the DOC who also confirmed that the medication cart must be locked when left unattended. [s. 129. (1) (a) (ii)]

Issued on this 9th day of September, 2020

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

Original report signed by the inspector.