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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 23, 2015	2014_331595_0012	S-000479-14	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 TRI-TOWN
143 BRUCE STREET P.O. BOX 999 HAILEYBURY ON P0J 1K0

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

MARINA MOFFATT (595), JANET MCNABB (579), SYLVIE LAVICTOIRE (603)

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): November 17, 18, 19, 20, 21, 24, 25, 26, & 27, 2014

The following log related to the Ministry of Health and Long-Term Care was also completed during the inspection: S-000236-14.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care, Nutrition Manager, RAI-Coordinator, Registered and Non-Registered Staff, Housekeeping Staff, Residents and Family Members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
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

During the course of this inspection, Non-Compliances were issued.
- **6 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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to Residents #9073 and #9067.

Inspector #603 reviewed Resident #9073's health care record. In the most recent care plan, the following interventions related to 'Activities' were identified for Resident #9073:

- Resident #9073 enjoys going out to visit family members;
- Staff are to encourage Resident #9073 to go on the outings the home offers like shopping or going to see the Christmas lights in the area, as well as participate in activities offered in the home;
- Resident #9073 requires assistance to attend and participate in activities due to a decline in their condition;
- Resident #9073 likes music, crafts, one-on-one visits and also enjoys socializing with other residents.

Inspector #603 interviewed Staff #106 who explained that Resident #9073 was not able to go on outings, and will not take part in activities, including crafts. Staff #106 continued to explain that the resident prefers to stay in their room and watch TV. Staff #106 confirmed that the resident's care plan was not up to date.

Inspector #603 interviewed Resident #9073 who identified that they will not attend nor participate in activities provided by the home. They choose to only attend specific events.

The licensee has failed to ensure that the care plan for Resident #9073 provides clear direction to staff in regards to the recreational preferences of Resident #9073.

Inspector #603 reviewed Resident #9067's health care record. On the most recent and previous care plans, it was documented that staff were to refer to the Behavioural Care Plan when Resident #9067 exhibited specific behaviours or requested tasks that could not be met by staff. Upon further review of the plan of care, Inspector #603 could not locate a Behavioural Care Plan for Resident #9067.

Inspector #595 interviewed Staff #100 who reported that the Behavioural Care Plan was no longer required for Resident #9067.

The licensee has failed to ensure that the care plan for Resident #9067 provides clear direction to staff in regards to behavioural interventions for Resident #9067. [s. 6. (1) (c)]

2. 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 Residents #9064, #9072, and #9076 so that their assessments are integrated, consistent with and complement each other.

Inspector #603 reviewed Resident #9064's health care record. It was documented in the MDS assessment dated October 15, 2014 that the resident had a wound that was not healed.

Inspector #603 interviewed Staff #100 and #112 who both reported that the resident's wound was healed. However, it still required a protective dressing until December 2, 2014 as per order.

Inspector #603 interviewed Staff #108 who completed and documented the October 15, 2014 MDS assessment. Staff #108 recalled the resident having a wound, and coded it as such in the MDS assessment.

Inspector #603 reviewed 'EO Weekly Wound Care Record' in Point Click Care dated

October 15, 2014 which identified that Resident #9064's wound was healed but still required monitoring and dressing due to high risk of skin breakdown.

Inspector #603 located an order by the Nurse Practitioner (effective October 15, 2014 until December 3, 2014) for Resident #9064's wound. Staff were also ordered to check the wound daily, change the dressing every five to seven days, and to monitor condition and effectiveness of therapeutic plan. Upon review of the Treatment Administration Record (TAR), it was identified that staff were following the Nurse Practitioner's orders and changing the dressing every five to six days.

The licensee has failed to ensure that the staff collaborated with each other in the assessments of Resident #9064's wound. [s. 6. (4) (a)]

Inspector #595 reviewed Resident #9072's care plan dated September 11, 2014. The care plan revealed the use of a medical device due to the resident's ongoing history of a medical condition.

Inspector #595 spoke with Staff #100 on November 26, 2014. This staff member confirmed that the medical device was implemented due to the ongoing medical condition.

Inspector #595 reviewed the Admission/Annual History as provided by Staff #102. The assessment, as completed by a physician on November 4, 2014, indicated that the use of the medical device was for a different, preventative measure.

The licensee has failed to ensure that the staff collaborated with each other in the assessment of Resident #9072 related to the use of a medical device. [s. 6. (4) (a)]

Inspector #595 reviewed the most recent care plan for Resident #9076. Under the section pertaining to pressure ulcers, it was documented that the resident had multiple pressure wounds.

Inspector #595 reviewed the most recent MDS assessment dated September 17, 2014 which indicated the presence of one pressure wound. Further review of the plan of care revealed weekly wound assessments documented on one pressure wound, and a physician's treatment order for the one pressure wound.

Inspector #595 spoke with Staff #100 on November 26, 2014 who informed Inspector

that Resident #9076 has one wound.

The licensee has failed to ensure that the staff collaborated with each other in the assessments of Resident #9076's wounds. [s. 6. (4) (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 to ensure that the plan of care for Residents #9073 and #9067 set out clear directions to staff and others who provide direct care to those residents; that staff and others involved in the different aspects of care collaborate with each other in the assessment of Residents #9064, #9072, and #9076 so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) 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. 53 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Responsive Behaviour Program is being evaluated annually and updated in accordance with evidence-based practices or prevailing practices.

Inspector #579 reviewed the Responsive Behaviour Policy #09-05-01. It was noted that the current version was dated September 2010. Inspector #595 interviewed Staff #102 who advised that the home had not completed a program evaluation update since that time. [s. 53. (3) (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 the Responsive Behaviour Program is evaluated annually, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation that could potentially trigger such altercations.

A Critical Incident (CI) report was submitted to the Director on January 26, 2014 due to

an incident of resident-to-resident abuse. The home reported that Resident #9067 walked into the dining room and saw that Resident #001 was sitting in their chair. Resident #9067 attempted to remove Resident #001 from the chair by grabbing their shoulder. Two staff attempted to intervene however Resident #9067 was already trying to tip the chair over with Resident #001 sitting in it. Staff members removed Resident #9067 from the dining room and moved Resident #001 out of harm. The Director of Care (DOC) and Physician were contacted, and agreed to call the Ontario Provincial Police (OPP) and send Resident #9067 to the hospital for assessment.

Inspector #603 reviewed the health care record for Resident #9067. Inspector #603 also reviewed Progress Notes and Behaviour Notes in Point Click Care which revealed an ongoing history of verbal aggression and threats towards other residents as outlined below:

On a previous day Resident #9067 was verbally aggressive and threatened to kill Resident #001 when they wandered into Resident #9067's room. Upon observation, a staff member removed Resident #001 from the room and another staff member spoke to Resident #9067. The staff member explained to Resident #9067 that they should ring the bell and call for staff should Resident #001 enter their room again. Resident #9067 explained to staff that they had rang the bell during previous incidents but no one came to answer it. Resident #001 was the same resident involved in the CI that occurred on January 26, 2014.

On another day Resident #9067 was observed by staff to be rude, sarcastic and threatening towards a confused resident wandering in the dining room. Staff intervened and advised Resident #9067 of techniques to address the wandering resident, however Resident #9067 continued with aggressive verbal statements towards the resident.

On another day Resident #9067 was noted to be yelling at a wandering resident and threatened to harm another resident. Resident #9067 became angry and verbalized further actions they would take to harm any resident who would enter their room. Resident #9067 stated to staff that they felt barricaded in their room by either closing the door or placing the yellow strip across the door. Documentation outlined that staff were called upon to "deal with the issue at hand to avoid further complications". Upon further discussion with Resident #9067, resident told staff of their intentions of physically harming another resident and that they would not consider the rationales or consequences of their future actions. Resident #9067 did not exhibit remorse throughout the discussion and stated "I don't care, I have had enough" and "You won't get me to

change my mind".

On a specific day in 2014 Resident #9067 became frustrated with Resident #001 and threatened to hit them. Staff intervened and told Resident #9067 that this was inappropriate.

One week later Resident #9067 was noted to be upset with a wandering resident at their doorway and began to yell at them. Resident #9067 was reminded to call upon staff for assistance to avoid these incidents.

On another day in 2014 Resident #9067 was observed to yell at a wandering resident and called staff for assistance to remove the wandering resident from their room.

Inspector #603 reviewed Resident #9067's care plan which stated that when Resident #9067 exhibited signs of anger and agitation staff were to refer to and follow the Behavioural Care Plan. Inspector #603 could not locate any behavioural care plan.

Inspector #595 interviewed Staff #100 who was unable to produce a behavioural care plan to address Resident #0967's responsive behaviours with the interventions to prevent recurrence.

Despite Resident #9067's ongoing behaviour, the licensee did not take steps to minimize the risk of altercations between Resident #9067 and other residents. [s. 54. (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 to ensure that the risk of altercations and potentially harmful interactions between residents, including Resident #9067, are minimized by identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff through observation, that could potentially trigger such altercations and by identifying and implementing interventions, to be implemented voluntarily.

WN #4: 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 any plan, policy, protocal, procedure, strategy or system instituted or otherwise put in place is complied with.

On November, 24, 2014 at 1130h, Inspector #603 observed a medication pass to resident #9035 by Staff #106. Upon review of the MAR, Inspector #603 noted that the order did not identify the dosage or specific directions to administer this medication.

Inspector #603 reviewed Resident #9035's Medication Review (Chart) Report dated September 2, 2014. The order identified the specific dosage and administration directions.

Inspector #603 reviewed the home's policy 'Pharmacy Policy & Procedure #8.3 Transcribing Prescriber's Orders to MAR/TAR' which indicated that when transcribing orders, staff are to include the name and strength of medication, dosage, route if other than oral, full directions, duration of treatment if specified, and the date of order. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the procedures developed for cleaning of the home, including resident bedroom floors, furnishings, contact surfaces, and common areas, were implemented.

Inspector #603 observed the rooms of Residents #9069, #9065, and #9052 which were noted to have an accumulation of dust on window sills, heat radiators, furniture, shelves, and wall hangings.

It was also noted by Inspector #603 that the rooms of Residents #9060 and #9052 had a large accumulation of dirt and sand along the base of the walls.

Inspector #603 interviewed Staff #103 and #104 who reported that the dusting does not get done on a regular basis, rather it gets done whenever they have time. Staff #104 stated that the only time they can complete dusting and washing the floors is when deep cleaning is completed. The deep cleaning schedule rotates between all rooms, with one room completed per week.

Inspector #603 reviewed the home's policy #HKLD-05-03-01 'Cleaning Frequencies' which indicated that the Hi/Low dusting in resident rooms was to be done weekly or bi-weekly. The vents are to be dusted weekly or bi-weekly. The resident floors are to be dust mopped and wet/damp mopped daily, and full wash weekly. [s. 87. (2) (a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

On November 19, 2014 at 1130h, Inspector #603 observed Staff #111 administer medication to Resident #9035. Staff #111 did not wash their hands before or after administering medication.

On November 24, 2014 Inspector #603 observed Staff #106 administer medications to Resident #9035. Staff #106 did not wash their hands before or after administering medications. When asked about the home's expectations around hand washing, Staff #106 informed Inspector #603 that staff would use the cleanser before the next resident only. The staff was observed to touch the medication cart and open drawers without washing their hands. [s. 229. (4)]

Issued on this 25th day of February, 2015

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

Original report signed by the inspector.