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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Oct 19, 2016	2016_522106_0001	028551-16	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

MARGOT BURNS-PROUTY (106), 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): October 3- 6, 2016.

Additional intakes completed during this inspections include: One complaint related to allegations of staff to resident abuse, one critical incident (CI) that the home submitted related to allegations of staff to resident abuse and two CIs the home submitted related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (ADM/DOC), Dietary Manager, Registered Dietitian (RD), Resident Assessment Instrument (RAI) Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, residents, and family members.

During the course of the inspection, the inspector(s) conducted a tour of resident home areas, observed the delivery of care and services to the residents, observed staff and resident interactions, reviewed resident health care records, various home policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 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. 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

On October 3, 2016, during a tour of the home, a resident room and the washrooms in two resident rooms were identified by Inspector #603, as having a strong odour of urine.

On October 4, 2016, Inspector #603 noted the urine odour in the same resident room and in the washrooms in the same two resident rooms.

Inspector #603 reviewed the home's policy titled, "Odours #HL-05-03-08", last revised in September 2015, which revealed that "All staff will immediately report any unacceptable lingering odour to the Support Services Manager and the Support Services Manager/Designate will identify the source of the odour by using Appendix 1 - Odour Control Investigation Tool as a guide".

Inspector #603 interviewed Housekeeping Staff #102 who explained that when a room had a strong smell of urine and they were unable to remove this odour, they were expected to advise their supervisor who would then intervene. Housekeeping staff #102 also explained that these concerns would not be documented in the maintenance request log book.

Inspector #603 interviewed the Administrator who was in charge of housekeeping. They stated that the policy reviewed by the Inspector was a corporate policy that they do not follow in the home. The Administrator explained that when staff had any concern of a room odour, it was expected that they would document this finding in the maintenance log book. The Administrator also reported that no staff members had reported the lingering odours to them, prior to the Inspector bringing it forward to them. The Administrator and the Inspector reviewed the maintenance log book and there were no entry for lingering offensive odours for the resident room and the washrooms in two residents rooms. [s. 87. (2) (d)]

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 as part of the organized program of housekeeping under clause 15(1) of the Act, procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #2: 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 an area or a medication cart that was used exclusively for drugs and drug-related supplies.

On October 3, 2016, Inspector #603 observed one staff member who was doing paper work in the medication room. At 1500 hours, staff were receiving shift report in the medication room.

On October 4, 2016, at 1500 hours, staff were observed conducting shift report in the medication room.

On October 5, 2016, Inspector #603 entered the home's medication room with RPN #100. In the room, where RPN #100 retrieved medication from the refrigerator and where the Inspector observed stored medication, there were two registered staff (one from night shift and one from day shift) who were counting and disposing of narcotics, one registered staff was working at a computer, and RPN students and other staff were conducting a meeting.

An interview with RPN #100 revealed that the medication room was also considered the report room and other staff such as PSWs or student nurses would enter this room for report.

During an interview with Inspector #603, the Administrator explained that the home used the medication room to store medications and for other purposes such as: to conduct daily shift reports, to store the physician book, communication book, policies and procedures, to conduct training, and for completing various paper work. [s. 129. (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 to ensure that drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, 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 the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #007 was triggered during stage one of the inspection, regarding a weight change.

On October 5, 2016, Inspector #603 reviewed resident #007's care plan which included a focus for high nutrition priority. The interventions indicated that for breakfast, the resident preferred a certain food item for breakfast, and staff were to provide a specific beverage at all meals.

On October 5, 2016, at 1245 hours, Inspector #603 observed resident #007 eating lunch in the dining room. Resident #007 did not have the specific beverage.

The Inspector reviewed the "Meal Service Report" utilized for October 5, 2016 and noted that it documented that the resident was not to receive the preferred food item and specific beverage was not included at lunch and dinner.

Inspector interviewed RN #103 who explained that according to the "Meal Service Report", resident #007 was only to receive the specific beverage at breakfast. [s. 6. (1) (c)]

2. Resident #002 was triggered during stage one of the inspection, regarding weight loss.

Inspector #106 reviewed the resident's plan of care and found:

The current three month Medication Review Report from August 2016 to November 2016, which indicated that resident #002 was to receive a dietary supplement with meals. The care plan document and the current Meal Service Report, did not include direction for the resident to receive the dietary supplement with meals.

On October 5, 2016, the Inspector interviewed the Registered Dietitian (RD) who reported that the resident had a current order for the dietary supplement with meals. On October 6, 2016, the Inspector interviewed the Dietary Manager who reported that they had not received any notification that the resident was to receive the dietary supplement with meals.

On October 6, 2016, the Inspector interviewed the Administrator/Director of Care (ADM/DOC) who stated that the order for the dietary supplement had been discontinued by the physician in May 2015. They also reported that the physician had continued to check the order for the dietary supplement, as renew on the Medication Review Reports, from June 2015 until the most recent review. [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. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

On October 5, 2016, during the breakfast meal Inspector #106 observed at 0914 hours, a bowl of cereal was placed in front of resident #002 and three other residents seated at the table. The staff member then walked away to complete another task. A staff member was not available to assist the resident with eating until 0920 hours.

Inspector #106 reviewed resident #002's care plan document and it indicated that staff were to provide total assistance with meals.

Inspector #106 interviewed PSW #108 and they reported that staff members that were assisting in the dining room were assigned a table that they were responsible for. The staff member was required to serve all the residents at that table. Once the residents were served, they would begin feeding the residents, who required assistance. [s. 73. (2) (b)]

Issued on this 19th day of October, 2016

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

Original report signed by the inspector.