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

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 # / No de registre	Type of Inspection / Genre d'inspection
Dec 7, 2017	2017_395613_0020	034970-16	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 VAN DAELE
39 Van Daele Street Sault Ste Marie ON P6B 4V3

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

LISA MOORE (613), JENNIFER LAURICELLA (542), MICHELLE BERARDI (679)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 20-24 & 27-30, 2017.

The following intakes were completed during this inspection:

One Follow up related to compliance order # 001 under s. 53 (4) of the LTCHA issued during inspection #2016_395613_0004 related to ensuring that the actions taken to meet the needs of residents with responsive behaviours included assessments, reassessments, interventions and documentation of the resident`s responses to the interventions.

One complaint related to concerns regarding the provisions of care of a resident;

Two Critical Incidents (CIs) the home submitted to the Director regarding alleged resident to resident abuse;

One Critical Incident the home submitted to the Director regarding alleged staff to resident abuse;

Eight Critical Incidents the home submitted to the Director regarding resident falls resulting in an injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager, Resident Assessment Instrument (RAI) Coordinator, Minimum Data Set (MDS) Coder, Behavioural Supports Ontario Registered Nurse and Personal Support Worker (BSO RN & BSO PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.

The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs, as well as staff personal files, training records, the home's internal investigation files and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 53. (4)	CO #001	2016_395613_0004	542

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan was provided to the resident as specified in the plan.

Inspector #613 reviewed a Critical Incident (CI) that was submitted to the Director in December 2016; identifying that, resident #007 had fallen out of their chair on to the floor and sustained an injury. The CI report revealed that PSW #107 had undone and removed a certain safety device from the chair, then left resident #007 unattended, while they were sitting in their chair, and went to get another PSW to assist them with transferring the resident. As a result, resident #007 fell out of their chair and onto the floor, sustained an injury and required transfer to the hospital.

A review of resident #007's care plan revealed as an intervention under the fall prevention focus that the resident was to have their certain safety device secured when they were in their chair to prevent independent transfers and walking.

A review of the Medication Administration Record (MAR) at the time of the incident, identified that a doctor's order was received in March 2012, for a certain safety device on their chair to prevent transfers.

A review of the investigation file identified that PSW #107 had taken responsibility for undoing the certain safety device and leaving resident #007 unattended while they got another PSW to assist them a specific type of transfer. PSW #107 was disciplined and received further training and education.

During an interview on November 24, 2017, with the Director of Care (DOC), they verified that PSW #107 had not followed resident #007's care plan and should not have taken the resident's safety device off of their chair until another PSW was in the room to assist. [s. 6. (7)]

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 care set out in the plan is provided to all residents as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that their abuse prevention policy was complied with.

Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director in August 2017; identifying that, resident #002 had reported to PSW #113 that a staff member, who had worked the previous shift, had been rough with them. The resident further reported to PSW #113 that they experienced discomfort to a specific area of their body from the staff member pushing them down when they tried to get up. The resident was unable to name the PSW, but was able to identify a specific trait of the alleged PSW.

A review of the home's policy titled, "Zero Tolerance of Resident Abuse and Neglect Program RC-02-01-01" last revised April 2017 identified that Extendicare was committed to providing a safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times.

A review of the home's investigation file revealed that PSW #106 had been the staff worker at the time of the alleged incident. A further review, identified that PSW #106 had admitted they had not assisted resident #002 with the provision of care, as the resident had requested, and had informed resident #002 that they would have to wait, then positioned the resident back into their bed. PSW #106 was disciplined for being rough during the provisions of care with resident #002 and for not providing assistance to the resident and meeting their needs, when they had requested.

During an interview on November 24, 2017, with the Director of Care (DOC), they verified that PSW#106 was disciplined as resident #002 had perceived PSW #106 as being rough during the provisions of care and PSW #106 had not met the needs of the resident, when resident #002 had requested assistance. PSW #106 received further training and education on abuse prevention and resident rights. [s. 20. (1)]

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 abuse prevention policy 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 any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff.

A) Resident #012 was identified as having a worsening altered skin integrity through their prior to most recent Resident Assessment Instrument-Minimum Data Set (RAI-MDS) assessments.

Inspector #679 reviewed the significant change in status MDS assessment dated June 2017, which outlined that the resident was exhibiting altered skin integrity to two areas. A review of the resident's quarterly MDS assessment dated September 2017, identified that the resident exhibited one area of altered skin integrity. Further, the Resident Assessment Protocols (RAPs) associated with the September 2017, assessment identified that the resident was experiencing an altered skin integrity to a specific area.

A review of the electronic assessments identified that a weekly wound assessment was not completed on two weeks in September 2017 and one week in October 2017.

B) Resident #010 was identified as acquiring a new area of altered skin integrity through their prior to most recent RAI -MDS assessments.

Inspector #679 reviewed the significant change in status MDS assessment dated July 2017, which outlined that the resident did not exhibit any areas of altered skin integrity. Further, a review of the significant change in status MDS assessment dated October 2017, outlined that the resident exhibited two areas of altered skin integrity. The associated RAPS identified that the resident was exhibiting two areas of altered skin integrity.

A review of the electronic assessments identified that a weekly wound assessment was not completed on one week in September 2017.

A review of the home's policy titled "Skin and Wound Program: Wound Care Management- RC-23-01-02" last revised February 2017, identified that any resident exhibiting any form of altered skin integrity, which may include but was not limited to skin breakdown, unexplained bruises, pressure ulcers, skin tears and wounds would be reassessed at least weekly by a nurse, if clinically indicated.

During an interview on November 23, 2017, with RN #101, they identified that skin assessments were to be completed weekly for any resident experiencing altered skin integrity.

During an interview on November 28, 2017, with the DOC, they identified that skin assessments were to be completed weekly. Inspector #679 and the DOC reviewed the online skin assessments for resident #012 and resident #010. The DOC verified that there was not a weekly skin assessment for resident #012 for two weeks in September 2017 and one week in October 2017. Further, the DOC verified that there was no weekly skin assessment for resident #010 on one week in September 2017. [s. 50. (2) (b) (iv)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

**s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Resident #017 was identified as having the presence of a urinary intervention through a RAI-MDS assessment.

Inspector #679 reviewed the most recent MDS assessment dated October 2017. The assessment identified that the resident had a urinary intervention.

A review of the progress notes identified that the resident had received the urinary intervention in May 2017.

A review of the current electronic care plan dated October 2017, identified that resident #017 had the urinary intervention in place.

A review of the electronic assessments identified that a continence assessment was not completed until October 2017, after the resident had received the urinary intervention in May 2017.

During an interview with the MDS Coder #110, they identified that continence assessments were to be completed upon admission, 72 hours post admission, with any deterioration or improvement in continence and with any change in condition that would

affect continence.

A review of the homes policy titled "Continence Management Program: RC-14-01-01" last revised in February 2017, identified that the nurse was responsible to complete a continence assessment using a clinically appropriate assessment tool that was specifically designed for assessing continence. An assessment was to be completed: upon admission for all residents, with any deterioration in continence level, required jurisdictional frequency and with any change in condition that may affect bladder and bowel continence".

During an interview on November 29, 2017, with the DOC, they indicated that continence assessments were to be completed with any change in continence. Further, the DOC verified that a continence assessment should have been completed for resident #017 when the resident received the urinary intervention. [s. 51. (2) (a)]

Issued on this 7th day of December, 2017

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

Original report signed by the inspector.