Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 30, Jun 2, 3, 4, Jul 4, 5, 6, Sep 19, 21, 2011	2011_056158_0001	Complaint

Licensee/Titulaire de permis

EXTENDICARE NORTHWESTERN ONTARIO INC
333 York Street, SUDBURY, ON, P3E-4S4

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

EXTENDICARE YORK
333 YORK STREET, SUDBURY, ON, P3E-5J3

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

KELLY-JEAN SCHIENBEIN (158)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Activity Manager, Environmental Manager, Assistant Director of Care from Extendicare Falconbridge who was present in the home, Registered staff (RN,RPN), Personal Support Workers (PSW), housekeeping staff, dietary staff and residents

During the course of the inspection, the inspector(s) conducted a walk throughout all resident home areas and some common areas, observed resident care, observed staff practices and interactions with residents, and reviewed the health care record of residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Pain

Personal Support Services

Snack Observation

Sufficient Staffing

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. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The inspector observed a resident sitting in the wheel chair in the dining room on June 3/11 at 0935h. At 10:05h, the resident started yelling out " I have to go to the toilet". One PSW was observed by the inspector to walk pass the dining room without acknowledging the resident's request. The licensee did not ensure that this resident's right to be properly cared for was provided.[s.3(1)4]
2. The inspector observed on June 3/11 at 09:05h, a registered staff member administer a resident's injection in the abdomen without providing the resident privacy. The licensee failed to ensure that the resident's right to privacy was provided.[s.3(1)8]
3. On June 2/11, the inspector observed a call bell on an unit ring. The resident stated to the inspector " I want help to go to the bathroom. I am not comfortable." The inspector observed one PSW enter the room and identified that she was busy and shut off the call bell. The PSW went to another resident's room. The resident rang five minutes later still requesting assistance. The same PSW answered the call bell and identified that she was still busy. The PSW stated that she was not assigned to the resident when questioned by the inspector. The inspector observed that the PSW then communicated to the PSW assigned to the resident, the resident's request. The resident rang for assistance a third time at which point the request for assistance was communicated to the registered staff by the inspector. The licensee failed to ensure that this resident's right to be treated with courtesy and respect and to respect the resident's dignity was done. [s.3(1)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 ensuring staff respond to resident's requests for assistance in a timely and respectful manner, to be implemented voluntarily.

WN #2: 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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. A tour of the home was conducted on June 2/11 by the inspector.
- The raised toilet seat in the shared bathrooms of three residents' rooms on one floor was observed by the inspector to be soiled with a brownish residue which was easily removed with a paper towel.
- The raised toilet seat located in the shared bathroom of a resident's room on a different floor was observed by the inspector to be soiled with a brownish residue that was easily removed with a paper towel by the inspector. A soiled bucket containing a plunger was found in the corner of this bathroom. As well, the area around the toilet was also soiled with a buildup of dirt.
- The dining rooms located on the second,third and fourth floors were observed by the inspector to have dirt build up and grit along the baseboards and at the corners of the doorways.
- There was dirt build up observed behind six resident's beds on one unit.
- Dirt build up behind the toilets and along the baseboards was observed in the shared bathrooms located in four resident's rooms.
The licensee failed to ensure that resident rooms, bath rooms, raised toilet seats and common rooms are kept clean.

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 ensuring that all resident rooms, bathrooms and common rooms are clean and that all raised toilets seats are clean, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. On June 2/11 at 10:45h and 2:35h, the inspector observed the PSW during the morning and afternoon nourishment pass on the west unit of an unit. The inspector observed the PSW leave the fluids and snacks on residents' bedside tables. The inspector did not observe the PSW to provide assistance or encouragement to the residents sitting in rooms. Both resident's care plans were reviewed by the inspector. It was identified that one staff is to provide encouragement with eating on both care plans.
The inspector observed that the morning juice, afternoon juice and afternoon snacks were still on resident bedside tables in two rooms at 17:00h.
Another PSW delivering nourishment on the east side of the same unit identified to the inspector on June 2/11 that the nourishment is delivered to the residents and assistance is provided as per the resident's need.
The licensee failed to ensure that the residents were provided with assistance or encouragement to safely eat and drink. [r.73(1)9]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

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;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. A walk throughout two units was conducted by the inspector on June 2/11 at 10:15h. The bathroom in one room was noted to have a stale urine smell. A fecal odour permeated the west hallway of this unit. The shared bathroom on another unit was observed to have a stale urine smell. A walk throughout the same two units was conducted by the inspector at 13:21h on June 2/11. Lingering urine odours were still present in the above bathrooms. The licensee did not ensure that procedures were developed or implemented to address incidents of lingering odours. [r.87(2)(d)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The home's medication and pain policy was reviewed by the inspector on June 3/11. The medication policy #11-05 identified that PRN (as needed) medication is assessed and the effectiveness of the medication is documented. The pain policy identified that the effectiveness of interventions are to be assessed and documented. A resident's health care record was reviewed by the inspector on June 3/11. An analgesic was ordered by the physician for the resident's pain. The resident's medication records and the progress notes were reviewed on June 3/11 by the inspector. The effectiveness of the medication given to the resident was not documented at the time of this review. [r.134(a)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following subsections:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times;
(b) is on at all times;
(c) allows calls to be cancelled only at the point of activation;
(d) is available at each bed, toilet, bath and shower location used by residents;
(e) is available in every area accessible by residents;
(f) clearly indicates when activated where the signal is coming from; and
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The inspector observed a resident sitting in the chair near the door on June 2/11 at 12:26h. The call bell was observed hanging behind the head of the bed and not within the resident's. [r.17(1)(a)]
2. A resident was observed rising from the bed to stand. The call bell was observed to be hanging behind the head of the bed and not within the resident's reach on June 2/11 at 12:24h.[r.17(1)(a)]
3. The inspector observed a resident in bed on June 2/11 at 12:19h. The call bell was hanging behind the head of the bed. The resident did not have access to the call bell.[r.17(1)(a)]
4. The inspector observed a resident resting in bed on June 2, 2011 and did not have the call Bell within Reach at 12:22h. [r.17(1)(a)]
5. The inspector observed a resident sitting in the chair by the door on June 2/11 at 12:15h. The call bell was behind the head of the bed. The resident did not have the call bell within reach at 12:15h. [r.17(1)(a)]
6. The licensee failed to ensure that the resident-staff communication and response system was easily accessed and used by residents at all times.

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 ensuring that the resident-staff communication and response system can be easily seen and accessed by all residents at all times, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. A resident complained to the inspector that the resident was cold. The inspector observed that the resident was sitting in the dining room under the cold air exchanger on June 3/11 at 10:10h. The resident was wearing shorts. The resident told the inspector "I didn't want to wear shorts but they put them on me anyway". The resident's care plan was reviewed by the inspector on June 3/11. The care plan identified that the resident requires total assistance of one person with dressing. The licensee did not ensure that the resident was dressed in keeping with the resident's expressed preference to not wear shorts on June 3/11.

WN #8: 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 subsections:

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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. On June 3/11 at 0930h, the inspector observed that a PSW coming out of a resident's room identified to another PSW that the the mesh bag for the resident's incontinence products was empty. The first PSW was also observed by the inspector to ask the other PSW what type of incontinent product the resident needed.
The PSW was questioned by the inspector on June 3/11 and stated that the resident's products are to be in their mesh bags in the room. The PSW was unable to state to the inspector what product the resident required or where the "tena" list was.
The resident's plan of care was reviewed by the inspector on June 3/11. Direction regarding the type and usage of the resident's incontinent product was not documented on the written care plan, however reference was made to refer to the tena/incontinence list. The resident's name or the product was not found on the incontinence list by the inspector on June 3/11. The resident's written plan of care did not set out clear direction with regards to continence care.[s.6(1)(c)
2. A swallowing assessment that identified a choking risk for one resident who had returned from hospital was completed by the dietitian. The interventions to prevent choking and to monitor the resident for choking during meals was not included in the plan of care.
The licensee failed to ensure the plan of care for this resident sets out clear direction with regards to nutritional care. [s.6 (1)(c)

Issued on this 21st day of September, 2011

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