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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 22, 2014	2014_140158_0001	S-0000147-13	Follow up

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 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 Follow up inspection.

This inspection was conducted on the following date(s): January 14 -16, 2014

Logs- S-000147-13, S-000108-13, S-000280-13, S-000521-13 and S-000522-13 were reviewed during this Follow Up Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Physiotherapist, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector(s) conducted a walk-through of resident home areas and various common areas, observed care provided to residents in the home, reviewed various home policies and reviewed residents' health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. Resident # 01 sustained a fracture when they fell in 2013. The resident had five further falls (some resulting in bruising) since the fracture in 2013. On January 16/14, the Inspector reviewed resident # 01 health care record, including the Physiotherapy Assessments, the Transfer/lift Assessments and resident # 01 care plan.
Four months post fracture, the physiotherapy assessments identified that assistance of 1 staff was required when transferring resident # 01 from a wheelchair (w/c) to the bed. As well, the assessment identified the use of a mechanical lift when needed to

transfer resident # 01.
It was identified in the next two quarterly physiotherapy assessments, that resident # 01 required assistance of 1 staff with the transfer.
It was identified in the most recent physiotherapy assessment that the resident was unable to weight bear and that a mechanical lift was now required to transfer resident # 01.
The Inspector reviewed five resident # 01 Transfer/lift Assessments conducted in 2013.
The first assessment identified that a mechanical lift using a specific sling was to be used, when the resident was unable to assist in the transfer.
The next two Transfer/lift Assessments, identified that resident # 01 only required the assistance of 1 staff to transfer from the bed to the wheelchair.
The fourth Transfer/lift Assessment did not identify any assistance for resident # 01 transfer.
The most recent Transfer/lift Assessment identified that resident # 01 required the assistance of 1 staff to transfer from the bed to the wheelchair.
The Inspector reviewed the transfer component of resident # 01 current plan of care, which identified that resident # 01 required assistance of 1 staff to transfer.
On January 16/14, the Inspector spoke with staff # S-105, who was providing direct care to resident # 01. Staff # S-105 identified that assistance of 1 staff is provided to resident # 01, however, when resident # 01 is tired, a mechanical lift is used. Staff # S-105 informed the Inspector that the assistance of 1 staff to transfer from the bed to the wheelchair was used when resident # 01 was transferred this am (January 16/14).
On January 16/13 (14:00h), the Inspector observed that prior to resident # 01 transfer, staff # S-105 stated to resident # 01, that the assistance of 1 staff to transfer them from the bed to the wheelchair would be used. The Inspector observed that resident # 01 stated to staff S-105, that they were in pain and could not participate in the above transfer. The Inspector observed that the resident`s assessed sized sling was not used when resident # 01 was transferred by two staff from the w/c into bed using a mechanical lift.
In summary, a resident Transfer/lift Assessment related to the type of mechanical lift and the use of the appropriately sized sling was not completed when resident # 01 transfer status changed. Also, the transfer change from one staff assistance to a mechanical lift was not communicated to the staff who provide direct care to the resident nor was this change identified in resident # 01 written care plan.
The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting resident # 01. [s. 36.]

2. Resident # 02 was admitted to hospital with a fracture in 2013 and was readmitted into the home four days later.
On January 16, 2014, the Inspector observed that two staff transferred resident # 02 from the bed into a wheel chair (w/c) using a mechanical lift and did not use the resident's assessed sized sling.
The Inspector reviewed resident # 02 health care records, which included the transfer/lift assessments, the physiotherapy assessments and resident # 02 care plans.
The transfer/lift assessments, conducted prior to resident # 02 fracture, and the quarterly assessments completed afterwards, identified that when transferring resident # 02 from the w/c to bed, a certain sized sling is used with the mechanical lift.
The physiotherapy assessment conducted prior to the resident # 02 fracture and three months after the fracture identified that a mechanical lift is required when resident # 02 is transferred.
The Inspector noted that a transfer/lift assessment or physiotherapy assessment was not completed when the resident was readmitted from the hospital, post fracture.
It was documented in the care plan prior to resident # 02 fracture that the assessed sized sling is used with the mechanical lift, when resident # 02 is transferred.
It was documented in the care plan, three months later, that a different type of sling (which had not been assessed) is used when resident # 02 is transferred with the mechanical lift.
It was documented in resident # 02 current care plan, that a specific assessed sling size is used with the mechanical lift, when resident # 02 is transferred.
On January 16/14, the Inspector interviewed staff # S-104, who stated that a type of sling (which had not been assessed) was previously used with the mechanical lift when resident # 02 was transferred but now a different sling/size (which had also not been assessed) is used.
In summary, a transfer/lift assessment was not completed when resident # 02 was readmitted from the hospital, post fracture and assessments for the different type of sling or the use of a different sized sling were not completed prior to their use with the mechanical lift in the transferring of resident # 02.
The licensee did not ensure that staff used safe transferring and positioning devices or techniques when assisting with resident # 02 transfer from bed to wheelchair. [s. 36.]

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 safe transferring is provided to all residents, especially resident # 01 and # 02 and that assessments related to the type of mechanical lift to use and the sling size are completed, that residents' care plans are updated and that the transfer change is communicated to the staff who provide direct care to residents, especially residents # 01 and # 02, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. In 2013, resident # 02 was transferred to the hospital, where it was determined that they had sustained a fracture. Resident # 02 was re-admitted into the home four days later with a specialized device. The progress notes identified that the resident returned to the home with the specialized device, which was to remain in place at all times until reassessed.
A review of resident # 02 health care record, showed that a Braden Skin Risk Assessment, a Head to Toe Skin Assessment and a Pain Assessment were completed when they were readmitted.
A transfer/lift assessment and a falls risk assessment identifying resident # 02 special need of the device, was not completed.
The Inspector noted that a quarterly nursing assessment had been completed prior to the fracture. Another quarterly nursing assessment was completed three months later, however, this assessment did not identify the resident's use of the specialized device after the fracture.
Documentation in resident # 02 progress notes by staff # 106 (11 days after the resident returned from hospital), indicated that there was difficulty with the positioning of the device and that the device was not being applied. It was also documented by staff # 106 that the physiotherapist assessed the resident but was unable to apply the device. The next day, the resident was assessed by the physician who ordered that further assessment of resident # 02 be done at the hospital. Resident # 02 returned from hospital with a new type of device. As per the physician's and surgeon's assessment and direction, strategies to keep the device in place were developed.
The Inspector reviewed resident # 02 care plans. Documentation related to resident # 02 special need of this device was not identified. The licensee failed to ensure that resident # 02 plan of care was based on an interdisciplinary assessment with respect to the resident's health conditions, including resident # 02 risk of falls and resident # 02 special need of a device. [s. 26. (3) 10.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. Resident # 02 was transferred to the hospital, where it was determined that they had sustained a fracture. A critical incident report was submitted to the Director on the next business day, however, the analysis portion, specifically the follow up/long term actions was not completed within the 10 day requirement.
The licensee who informed the Director of an incident under subsection (1), (3) or (3.1) failed to make a report in writing to the Director setting out the analysis and follow-up action, including, the long-term actions planned to correct the situation and prevent recurrence within 10 days of becoming aware of the incident. [s. 107. (4) 4. ii.]

WN #4: 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. In 2013, resident # 02 sustained a fracture and was admitted to hospital. The resident returned to the home four days later. The Inspector reviewed the home's pain policy, which identified that the pain flow note in the progress notes must be completed pre and post medication to assess the effectiveness of the medication/treatment. The Inspector reviewed resident # 02 health care record. A drug for pain management was ordered by the physician every 4hrs as required. The Inspector reviewed resident # 02 progress notes, specifically the pain flow notes, the medication administration notes, the progress notes and the progress notes DAR. It was noted that the effectiveness of the drug administered to resident # 02 was not evaluated six times.
The licensee failed to ensure that monitoring and documentation of resident # 02 response and the effectiveness of the drugs she received for pain management was documented. [s. 134. (a)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2013_138151_0008	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #006	2013_138151_0008	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2013_140158_0014	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (2)	CO #002	2013_138151_0008	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #003	2013_138151_0008	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (5)	CO #004	2013_138151_0008	158
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #005	2013_138151_0008	158

Issued on this 22nd day of January, 2014

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