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
Aug 8, 2013	2013_193150_0019	O-000666-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST, SCARBOROUGH, ON, M1G-1R6

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

CAROLE BARIL (150)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 24,25, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurse, Registered Practical Nurse, Physiotherapist, Physician.

During the course of the inspection, the inspector(s) reviewed the resident's health records, policies: Care of Residents with Diabetes Mellitus #CLIN-05-07-03, Frequency of Recording #HEAL-04-03-08, Admission, Re-admissions and On-Hold Medications #11-01 date of origin September 2010.

The following Inspection Protocols were used during this inspection:
Hospitalization and Death

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. (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 comply with LTCHA, 2007 S.O. 2007, c8, s.6 (4) (a) as the home did not ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of resident #1.

Resident #1 had a known diagnosis of diabetes and other diagnosis which contributed to fluctuating blood sugar for which was prescribed accucheck monitoring 3 times a day before meals at 07h30, 11h30 and 16h30.

On a specific date in July 2013, the physician prescribed to restart the specific Insulin and put on hold a previous insulin prescribed.

On a specific date in 2013, in an interviewed with the RN#1, states that since the admission, the resident was known to have fluctuating blood sugar and periods of fatigue and sleeping for a few days.

On a specific date in July 2013, the RN#1 states that the prescribed insulin on hold was re-assessed with the physician weekly. The RN states that the physician had communicated to the staff that it was decided to keep the medication on hold for this resident due to the resident's diagnosis and fluctuating blood sugar. The physician had indicated that there will be no prescribe insulin on a sliding scale for this resident and that the concern was mostly the resident's low blood sugar instead of high blood sugar.

The Medication Administration Records of July 2013 documented the blood sugars results for specific dates in July 2013 to be elevated.

On a specific date in July 2013, the physiotherapist noted that "the resident was very sleepy and drowsy".

On a specific date in July 2013, RPN noted in the early afternoon that "resident had meals, friend visited, elevated blood sugar, informed RN, no distress noted".

On a specific date in July 2013, RN noted in the afternoon that "resident up in a wheelchair, ate dinner with good appetite. Verbally responsive and able to maintain eye contact".

On a specific date in July 2013, in the evening documented that "PSW reported to the

RN that the resident is not responding when the resident's name is called out", 911 called and the resident was transferred to the hospital.

No documentation noted on the resident's chart related to the Registered Nurse interventions.

The administrator and Director of Care confirmed that the Registered Nurse did not comply to the home's policy related to charting.

On July 25, 2013, in a telephone interview, the treating physician states the resident was well known for having on going fluctuating blood sugar and that the concern of the resident's low blood sugar was greater than high blood sugar due to the resident's diagnosis.

The physician confirmed of being on call on the specific dates in 2013 and did not receive any call related to the elevated blood sugar of this resident.

The treating physician states that if informed of elevated blood sugar, a stat order of short acting insulin would have been prescribed to stabilize the elevated blood sugar and repeat the resident's blood sugar in 1 hour.

On a specific date in July 2013, documented in the progress notes "the emergency department informed the home that the resident deceased immediately after the resident arrived at the hospital". [s. 6. (4)]

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 by ensuring that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident., to be implemented voluntarily.

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Issued on this 12th day of August, 2013

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