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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 25, 26, May 1, 2, 3, 4, 7, 8, 2012	2012_043157_0015	Complaint

Log#002313-11
V Ref 001504-11

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 COBOURG
130 NEW DENSMORE ROAD, COBOURG, ON, K9A-5W2

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

PATRICIA POWERS (157)

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 home's Administrator and Director of Care.

During the course of the inspection, the inspector(s) reviewed the clinical health record of four identified residents, observed care practices and procedures on an identified unit.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Medication

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

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. 131. Administration of drugs

Specifically failed to comply with the following subsections:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. Medication administration records for resident #01 indicate that an identified medication was not administered to the resident in accordance with the directions for use specified by the prescriber on as follows:
- On two dates in August, two dates in September, and three dates in October, the Medication Administration Record for 2100 hours was coded "5" to reflect "Drug Ordered not Received". Progress notes for the resident indicate that the home was awaiting delivery from the pharmacy.
- On two dates in October, the Medication Administration Record for 2100 hours was coded "7" to reflect "Other", with no further explanation of why the medication was not administered. [r.131(2)]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to immediately notify a resident's substitute decision maker of a witnessed incident of abuse of a resident that caused distress to the resident and was potentially detrimental to the resident's well-being, as evidenced by the following:
- Progress notes indicate that resident #01 was very resistive to admission to the home and for a period of time refused to enter the building and subsequently refused to enter the care unit. It was noted that that the resident's family member was very anxious.
- Three days after the resident's admission staff investigated a "loud scream" and found another resident striking resident #01. The resident did not have any physical injury but was noted to be upset by the incident. PSW progress notes recorded on the date of the incident at 1330 hours indicates that the resident was very "upset and crying" as a result of this incident.
- An RN entry in the progress notes at 1417 hours the day following this incident states the resident's Substitute Decision Maker was notified about the about the incident which occurred the previous day.
- A progress note entry five days later describes bruising on both forearms and upper left arm, right thigh and lower left leg. Notes state the resident "did have an altercation with another resident since admission which may be the cause". [r.97(1)(a)]

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 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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met;
(b) the resident's care needs change or care set out in the plan is no longer necessary; or
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. Progress notes and Head to Toe Skin Assessments for resident #01 indicate 6 occasions over the period of a year where the resident had bruising. On all but one of these occasions the bruising was of an unknown origin. The residents plan of care fails to provide clear direction to staff related to the resident's tendency for bruising and preventative, protective interventions are not identified. [s.6(1)(c)]
2. Progress notes for resident #01 indicate a change of medications, to be assessed related to the resident's tendency to bruise easily. The plan of care does not indicate any further assessment related to this change of medication. The resident's MDS assessment does not identify that resident bruises easily or provide direction for any assessments or interventions required.[s.6.(10(b)]

Issued on this 8th day of May, 2012

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

Pat Burns #157