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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2019	2018_598570_0015	026834-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Oshawa
82 Park Road North OSHAWA ON L1J 4L1

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

SAMI JAROUR (570), COREY GREEN (722)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 10, 11, 15, 16, 17, 18 and 19, 2018

Complaint Log #026834-18 related to multiple care concerns including an allegation of abuse/neglect, transferring and positioning, continence care, nutrition care and hydration, cooling requirements, bathing, resident's drug regimes and medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Support Services Manager, Registered Dietitian (RD), Dietary Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI MDS Co-ordinator, RAI MDS Super Coders, Physiotherapist (PT), Physiotherapy Assistant (PTA), and Physician.

In addition, the Inspector(s) observed staff to residents interactions, resident to resident interactions, observed a tray service, reviewed clinical health care records for identified resident, reviewed complaint logs, education records, and relevant policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

Findings/Faits saillants :

1. The licensee had failed to ensure that the written plan of care for each resident sets out the planned care for the resident.

The MOHLTC ACTION Line received a complaint on an identified date. The complainant indicated a number of care concerns related to resident #001.

A telephone interview was carried out on identified date with the complainant. The complainant indicated that resident #001 used an incontinent product as they were not able to toilet themselves. The resident was transferred to hospital on identified date, and passed away while in the hospital.

A review of health records for resident #001 indicated the resident was transferred from hospital to the convalescent care program (CCP) at the home on an identified date, after sustaining an injury. The record review confirmed that the resident was transferred to hospital on an identified date, and passed away while in the hospital.

A review of resident #001's health records for an identified period, was carried out:
- The patient transfer record for resident #001, indicated that the resident was incontinent of both bowel and bladder.
- The convalescent care summary of new admission document indicated that the resident was continent of bladder and bowel and the resident required limited assistance with toileting.
- The Community Care Access Center (CCAC) Minimum Data Set Home Care (MDS-HC) assessment completed prior to admission to the home, for resident #001 indicated that resident #001 was continent of bladder and bowel. The resident used an incontinent product and an assistive device to promote continence.
- The Minimum Data Set (MDS) and Resident Assessment Protocols (RAP) assessment

completed for resident #001 in a specified date following admission to the home, indicated urinary incontinence was triggered. The resident was identified as occasionally incontinent and required a use of incontinent product. The RAP review indicated that, the plan of care reflected incontinence needs support.

A review of resident #001's written plan of care, indicated that the plan of care did not identify the resident's continence status and interventions put in place to manage the resident's incontinence. The plan of care indicated that the resident had impaired ability for toilet use related to an identified medical diagnosis. The plan of care outlined that the resident required limited assistance including assistance with adjusting clothing and guided assistance as needed.

During an interview with Inspector #570, PSW #101 indicated that resident #001 was continent of bladder and bowel. The resident also used an incontinent product and a device to promote continence.

During an interview with Inspector #570, PSW #103 indicated that resident #001 used an incontinent product all the time. The resident was able to inform staff of the need to be toileted or use an identified assistive device for toileting.

During an interview with Inspector #570, PSW #106 indicated that resident #001 would ring the call bell for staff to provide an identified assistive device for toileting. The resident was continent of bowel and sometimes incontinent in bladder. The resident used identified assistive devices for toileting but also used an incontinent product in case of an accident.

During an interview with Inspector #570, PSW #113 indicated that resident #001 would be toileted in bed due to bowel incontinence. The resident did not use an identified assistive device for toileting as it was uncomfortable. The resident used an identified assistive device to promote bladder continence and would call staff to clean the device. PSW #113 further indicated that the resident was admitted from hospital to the home wearing an incontinent product and required this product as the resident was incontinent of bowel and sometimes of bladder.

During an interview with Inspector #570, RPN #123 indicated MDS RAPs assessment completed, for resident #001 identified urinary incontinence as a trigger. The RPN indicated that the urinary incontinence trigger was not addressed in the written plan of care. The RPN further indicated that registered staff in the convalescent care unit should

have assessed the resident and updated the written plan of care.

During an interview with Inspector #570, the Director of Care (DOC) confirmed that urinary incontinence was triggered for resident #001 and that the expectation was to develop a plan of care to address the urinary incontinence trigger. Upon review of the written plan of care for resident #001 with the DOC, the DOC confirmed that the plan of care did not reflect the continence care provided to the resident. The DOC indicated that resident #001 was able to articulate the need to use an identified assistive device for toileting. The DOC further indicated that PSW staff should have reported to registered staff that the interventions used for the resident were not included in the written plan of care and that the plan needed to be updated.

The licensee did not ensure that the written plan of care for resident #001 set out the planned care for the resident specific to continence care provided. [s. 6. (1) (a)]

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 the written plan of care sets out the planned care for each resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to food and fluid intake monitoring policy.

O. Reg. 79/10, s. 68 (2) (d) states every licensee of a long term care home shall ensure that the organized program of hydration include a system to monitor and evaluate the fluid intake of residents with identified risks related nutrition and hydration.

The licensee's policy #RC-18-01-01 "Food and Fluid Intake Monitoring" states: Each resident's food and fluid intake will be monitored as an ongoing indicator of nutritional and hydration status and individually assessed for significant changes. Corrective actions will be taken and outcomes evaluated for identified resident intake concerns.
Policy also states on page 2 under fluid intake monitoring, nurse/interdisciplinary team:
1. Review fluid intake records daily and compare to individualized fluid target, as assessed by the Registered Dietitian/Designate.
2. If a resident consumes less than their individualized fluid target level for three (3) consecutive days, the nurse must take into account additional fluids taken with medication, supplements and other fluids not provided at meals or snack times. Homes may use the Daily Fluid Intake Monitoring Communication Tool, to communicate between shifts, Chart rationale in progress notes for not completing a hydration assessment.
3. If after considering additional fluid intake, the resident still has not met their individualized fluid target for three (3) consecutive days, the nurse must complete a Nursing Hydration Assessment.

The MOHLTC ACTION Line received a complaint on an identified date. The complainant indicated a number of care concerns related to resident #001. A telephone interview was carried out on identified date with the complainant. The complainant indicated that resident #001 was dehydrated and passed away after they were transferred to hospital on an identified date.

A review of health records for resident #001 indicated the resident was transferred from hospital to the convalescent care program (CCP) at the home on an identified date, after sustaining an injury. The record review confirmed that the resident was transferred to hospital on an identified date, and passed away while in the hospital.

A review of the plan of care for resident #001 indicated the resident would meet nutritional needs of: energy 1962kcal (BEE x 1.2 x 1.1), fluids 1850ml or 15 glasses (based on 25ml/kg) and protein 81.5g (1.1g/kg) per day.

A review of progress notes for resident #001 indicated:
- On identified date, nine days prior to transfer resident #001 to hospital, RN #114 documented, resident below required fluid intake, please push fluids.
- On an identified, seven days prior to transfer resident #001 to hospital, the registered dietitian (RD) documented that the daily average fluid intake at 1250 mls plus med pass. The resident currently not consuming adequate fluids as outlined in plan of care. No signs or symptoms of dehydration. Fluid intake will need to be monitored and referral made to dietitian should the resident not meeting their goals on consistent basis
- On identified date, two days prior to transfer resident #001 to hospital, RN #125 documented: resident below required fluid intake, please push fluids.
- On identified date, one day prior to transfer resident #001 to hospital, RN #114 documented: resident below required fluid intake, please push fluids. Later that same day, RPN #112 documented: encouraged the resident to drink more fluid.
- On identified date and time prior to transfer resident #001 to hospital that day, RN #114 documented: resident below required fluid intake, please push fluids.
- On identified date and time prior to transfer resident #001 to hospital that same day, RPN #116 documented in a late entry that resident #001 was assessed during the day. The resident wanted to remain in bed for dinner, lips dry, pallet moist, resident was given 75 mls of water, tolerated well.

A review of fluids intake record documentation for resident #001 provided to Inspector #570 by the DOC indicated the resident's total fluids consumed for an identified period of one month, were recorded 25 times as below 12 glasses on identified dates.

An interview with the registered dietitian (RD) by Inspector #570 indicated that resident #001's initial assessment was completed 24 days after admission, and that the plan of care identifying fluid intake requirement for the resident was initiated the following day post initial assessment. The RD indicated that resident's minimum fluid intake should be 75% of 15 glasses which is calculated at 12 glasses per day. The RD indicated that the assessment revealed that resident #001 was not drinking enough fluids for two weeks look back period from the initial assessment date, thus recommended to monitor fluid intake and refer resident to the RD, if the resident was not meeting their fluid intake requirement on a consistent basis. The RD further indicated that nursing staff would do a hydration assessment to determine if a referral to the RD or physician is needed and to put interventions in place.

An interview with registered nurse (RN) #114 by Inspector #570, indicated that residents'

fluid intake is reviewed on the night shift; each resident should receive 10 glasses of fluid, 125 mls each glass for the previous three days. Anything less than 10 glasses for three days in a row, a progress note is made that the resident was below required amount of fluid intake; then, the day shift registered staff should assess residents for any signs of dehydration and direct PSW staff to push fluids. The RN explained that the 10 glasses or a 1250 mls benchmark was the instruction given on hire to use when reviewing fluid intakes for all residents. The RN confirmed that a progress note documentation on identified date, noted that resident #001 was below the required fluid intake for the previous three days using the benchmark of 10 glasses.

An interview with the Director of Care (DOC) by Inspector #570 indicated that the night shift registered staff review the total fluid intake forms. They would look at fluid target determined by the dietitian and 75% of identified number of glasses. When the fluid intake target is not identified by the dietitian, the staff will consider 10 glasses as a target based on the average weight of all residents. The DOC further indicated that resident #001's fluid intake was not reviewed using an individualized fluid target as indicated in the policy, until the resident was assessed by the dietitian on an identified date, completed 24 days post admission. The DOC further indicated that staff continued to push fluid for resident #001, but no hydration assessment was completed. The DOC indicated that staff need to be educated on completing the hydration assessment, even if the resident did not present symptoms of dehydration.

During an interview with Inspector #570, the Director of Care (DOC) indicated that staff are directed to use 10 glasses as a fluid target when there is no specification by the dietitian. The DOC further indicated that they can be considered the dietitian designate in this case. The DOC further explained that they did not assess resident #001 for individualized fluid target and that the 10 glasses was a reasonable average for short term use for 10 to 14 days until the resident was assessed by the dietitian. The DOC also confirmed that having the short term use of 10 glasses should not be extended to 21 days as the dietitian would have assessed the residents within 7 days.

The licensee's policy related to food and fluid intake monitoring was not complied with when an individualized fluid intake target was not used for resident's #001 and a hydration assessment was not completed for the resident when the resident continued to have low fluid intake for more than three consecutive days. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific height and weight

monitoring policy.

O. Reg. 79/10, s. 68 (2) (e) states every licensee of a long term care home shall ensure that the organized program of hydration include a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

The licensee's policy #RC-18-01-06 "Height and Weight Monitoring" states: All residents will be weighed on admission and monitored at least once a month thereafter and whenever a significant change occurs that can affect the resident's weight.

Review of weights summary for resident #001 on Point Click Care (PCC) indicated the first recorded weight was identified 13 days post admission date to the home.

An interview with the registered dietitian (RD) by Inspector #570 indicated that residents are to be weighed on admission and that resident #001 should have been weighed on admission date.

During an interview with Inspector #570, the Director of Care (DOC) indicated that resident #001's weight was taken on identified date, 13 days post admission, and the weight should have been taken and recorded on admission date.

The licensee's policy related to height and weight monitoring was not complied with when resident #001 was not weighed on admission. [s. 8. (1) (a),s. 8. (1) (b)]

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 food and fluid intake monitoring policy, and height and weight monitoring policy are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care

Specifically failed to comply with the following:

s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that the initial plan of care was developed within 21 days of admission specific to hydration status and risk related to hydration.

A review of health records for resident #001 indicated the resident was transferred from hospital to the convalescent care program (CCP) at the home on an identified date, after sustaining an injury. The record review confirmed that the resident was transferred to hospital on an identified date, and passed away while in the hospital.

A review of resident #001's health records for an identified period of one month, was carried out. The MDS Resident Assessment Profile (RAP) dated completed 14 days post admission, revealed that dehydration / fluid maintenance was triggered. The resident was identified as being administered diuretics daily for the last 7 days preceding the assessment date. The RAP note indicated that the plan of care reflected interventions to support hydration and manage swelling.

A review of resident #001's written plan of care, revealed that the plan of care did not identify the resident being triggered for dehydration and no interventions were put in place, although the resident was triggered for dehydration on an identified date, 14 days post admission. The plan of care indicated a focus related to eating and that the resident required assistance with setup for meals. The plan of care indicated a focus on nutrition, initiated 25 days post admission by the dietitian, related to diet and fluid and the resident was identified to be at moderate nutritional risk.

During an interview with Inspector #570, the registered dietitian (RD) indicated that they usually complete the nutrition plan of care within 21 days after admission. The RD indicated that resident #001's plan of care was initiated on identified date, after 25 days from admission date.

During an interview with Inspector #570, RPN #123 confirmed that the MDS RAPs assessment completed 14 days post admission, for resident #001 indicated dehydration / fluid maintenance as an identified trigger. The RPN indicated that the dehydration trigger was not addressed in the written plan of care. The RPN further indicated that registered staff on the convalescent care unit should have assessed the resident and updated the plan of care.

During an interview with Inspector #570, the DOC confirmed that dehydration was triggered for resident #001 and that the expectation was to develop a plan of care to address the triggered item. Upon review of the written plan of care for resident #001 with the DOC, the DOC confirmed that the plan of care did not include any interventions related to dehydration. The DOC further indicated that the staff in charge of completing the RAI MDS assessments should have placed interventions in the plan of care to address dehydration trigger but this was not done.

The licensee did not ensure that the initial plan of care was developed for resident #001 within 21 days of admission specific to hydration status and any risk related to hydration. The plan of care related to diet and fluid was initiated by the dietitian 25 days after the resident was admitted to the home. [s. 25. (1) (b)]

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 ensure that the initial plan of care was developed within 21 days of admission specific to hydration status and risk relating to hydration, to be implemented voluntarily.

WN #4: 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. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that a registered dietitian, who is a member of the staff of the home, completed a nutritional assessment for the resident on admission.

A review of health records for resident #001 indicated the resident was transferred from hospital to the convalescent care program (CCP) at the home on an identified date, after sustaining an injury. The record review confirmed that the resident was transferred to hospital on an identified date, and passed away while in the hospital.

A review of the health records for resident #001 revealed that a referral was sent to the dietitian on admission date, with reason for referral identified as new admission. The record review revealed that a registered dietitian assessment was not completed until 24 days after admission date. The records review identified that the Oral/Nutritional status of the admission RAI MDS assessment was completed by registered nursing staff.

During an interview with Inspector #570, the registered dietitian (RD) indicated that the initial assessment is usually completed within 14 to 21 days after admission. The RD indicated that resident #001's initial assessment was completed on identified date, 24 days post admission date, and interventions placed in plan of care the following date post initial assessment. The RD further indicated not being present in the home during the last week of month when resident #001 was admitted to the home, and if a dietitian was needed, the home could have contacted the corporate office.

During an interview with Inspector #570, the Director of Care (DOC) indicated that resident should have been assessed by the dietitian within 10 days of admission.

The registered dietitian did not complete the admission assessment for resident #001 until 24 days after the resident was admitted. [s. 26. (4) (a),s. 26. (4) (b)]

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 a registered dietitian, who is a member of the staff of the home, complete a nutritional assessment for the resident on admission, to be implemented voluntarily.

Issued on this 8th day of January, 2019

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

Original report signed by the inspector.