Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Dec 10, 2013	2013_220111_0019	O-000203-13	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 GUILDWOOD
60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs
LYNDA BROWN (111)

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 28 & 29, 2013

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Dietician, and Laundry Aide.

During the course of the inspection, the inspector(s) reviewed the health record of a deceased resident and reviewed the home's policy on weight changes and falls.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Dignity, Choice and Privacy
Falls Prevention
Nutrition and Hydration
Pain

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care set as set out the plan was based on an assessment of the resident and the needs and preferences of the resident.[s. 6. (2)]

Review of Medication Administration Record (MAR) for Resident #1 indicated the resident received an analgesic three times daily and as needed. Review of the RAI-MDS and care plan did not identify that Resident #1 had pain or why the resident was receiving the analgesic.

Review of the resident's pain assessment's indicated a pain assessment had not been completed for a period of five months and the last pain assessment completed indicated "no pain" and no indication why the resident was receiving the analgesic.

2. There was no documented evidence Resident#1's SDM was notified of the resident's change in condition until the next day and there was no documented evidence the resident's SDM was notified of a fall.[s.6. (5)]

3. There was no indication when Resident#1 care needs changed, the resident's plan of care was reviewed and revised until the following shift when the next shift also noted a change in the resident's condition and notified the physician.[s. 6.(10)(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 the plan of care of resident's is based on the assessment of the resident's needs and preferences, that the residents substitute decision maker (SDM) (if any), and any other persons designated by the resident or SDM are given an opportunity to participate fully in the development and implementation of the resident's plan of care, and that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change,, 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. Under O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

Review of the homes "Falls Policy" (RES-09-0201) indicated:
When a resident falls:
-immediately complete an initial physical and neurological assessment of the resident,
-residents are to have a Fall Risk Assessment completed after a resident sustains a fall,
-notification of family/SDM,
-complete the Resident Incident Report and a Post-fall Analysis Report,
-document as required in the progress notes of the occurrence,
-review and update the resident's care plan with any new interventions based on the resident post-fall analysis.

Review of Resident#1 progress notes indicated there was no documented evidence of an actual fall that occurred, no indication the POA was notified of the fall, no indication of a fall incident report, and no indication of a post-fall analysis report, and the Falls Risk Assessment was completed five days after the fall. [s. 8. (1)]

Issued on this 16th day of December, 2013

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