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**

**Division de la responsabilisation et de la performance du système de santé**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 1, 2015 | 2015_324567_0008 | T-1664-15 | Resident Quality Inspection |

### 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 GUILDWOOD
60 GUILDWOOD PARKWAY SCARBOROUGH ON M1E 1N9

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

SOFIA DASILVA (567), JOANNE ZAHUR (589), SUSAN SEMEREDY (501)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): July 22, 23, 24, 27, 28, 29, 30, 31, 4, 5, 2015.**

**Order, log no. T-002147-15, was followed up during the RQI.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Coordinator, Resident Program Manager, Registered Dietitian (RD), Physiotherapist, Environmental Manager, Activationist, Support Services Aide, Registered Staff, Personal Support Workers,Private Caregivers, and Presidents of Resident and Family Councils.**

**During the course of the inspection, the inspector(s)conducted a tour of the home,made observations of meal service, observed medication administration, observed staff and resident interactions and the provision of care, conducted reviews of health records, complaint and critical incident record logs, staff training records, meeting minutes of Residents' and Family Council meetings and reviewed relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Dining Observation**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Nutrition and Hydration**
**Personal Support Services**
**Recreation and Social Activities**
**Residents' Council**
**Safe and Secure Home**
**Skin and Wound Care**

**During the course of this inspection, Non-Compliances were issued.**

- **7 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| 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. 19. (1) | CO #001 | 2015_369153_0003 | 567 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 68. Nutrition care and hydration programs**

**Specifically failed to comply with the following:**

**s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,**
**(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).**
**(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).**
**(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).**
**(e) 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. O. Reg. 79/10, s. 68 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the hydration program includes the implementation of interventions to mitigate and manage the identified risks related to hydration.

Review of the fluid tracking records revealed that resident #030's fluid intake from June 15 to July 29, 2015, ranged from 0-500 millilitres daily. Review of the resident's admission nutrition assessment dated as per his/her admission date, revealed that resident #030 required 2580 millilitres of fluid per day.

Review of the home's policy, titled "Food and Fluid Intake Monitoring", #RESI-05-02-05, dated September 2014, revealed that if a resident consumes less than their minimum fluid target levels for three consecutive days, the resident requires a hydration assessment which must be documented.

Review of the fluid and hydration assessment procedure, located in the fluid tracking binder, and interview with the RD revealed that registered staff on the night shift are to generate a fluid report daily for each resident and are to communicate to day shift registered staff if a resident's intake is less than the target. The registered staff will then conduct a hydration assessment for each of these residents.

Interview with the RD confirmed that the registered staff did not conduct a hydration assessment for resident #030. It was revealed that the computer program that the PSWs used to record this resident's fluid intake was faulty and was only tallying one out of six possible fluid intake times. The RD confirmed that the home would have to resolve this issue. [s. 68. (2) (c)]

***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 the hydration program includes the implementation of interventions to mitigate and manage the identified risks related to hydration, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program**

**Specifically failed to comply with the following:**

**s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:**
**1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents admitted to the home are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review revealed that resident #003 was admitted on a specified date, and did not receive any tuberculosis (TB) screening. Record review revealed resident #031 was admitted to the home a specified date and only received step one of the two step turberculin skin test. Interview with the DOC confirmed that resident #003 did not receive any TB screening and resident #031's screening was not complete. [s. 229. (10) 1.]

***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 residents admitted to the home are screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's right to be treated in a way that fully recognizes their individuality and respects their dignity is fully respected and promoted.

Interview with resident #002 revealed that a request for an incontinence product was made to the home. Resident #002 stated that he/she had been told that getting the requested product was not possible.

Interviews with the EM and PT revealed that the issue of concern to the resident was not addressed and that the home would look into alternatives to meet the needs of resident #002.

Interview with the DOC confirmed that the home did not fully respect and promote resident #002's individuality and respect his/her dignity in regards to providing an appropriate incontinence plan. [s. 3. (1) 1.]

2. The licensee has failed to ensure that the following rights of residents are fully respected and promoted:
Every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On July 30 and 31, 2015, the inspector observed registered staff #114 and #117 dispose of empty medication pouches in the regular garbage attached to their medication carts.

Interviews with registered staff #114 and #117 revealed that at the end of their shift the garbage is disposed of in a large garbage bin that is picked up by housekeeping staff and that is the practice in the home. Neither staff member was aware of what happened to this garbage after housekeeping disposed of it and that residents' personal health information was not being kept confidential.

Interview with the DOC confirmed that disposing of used resident medication pouches in the regular garbage did not keep residents' personal health information confidential in accordance with the Act. [s. 3. (1) 11. iv.]

**WN #4: 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).**

**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 failed to ensure that there is a written plan of care related to oral care hygiene for resident #003.

Resident #003 was admitted to the home on a specified date in 2015. Record review of the most recent written plan of care did not include oral care hygiene requirements and needs.

Interview with registered staff #111 revealed and confirmed that resident #003's oral care hygiene needs were not identified in the written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident

A review of the resident #006's written plan of care revealed that the resident is to use a device for safety. The written plan of care also states that the device is not a restraint. Interview with RN #103 revealed that it is to be used at the request of the resident's

family. The written plan of care also states that the resident is unable to transfer him/herself and makes no attempt to transfer self.

Observations made by the inspector on July 27 and July 28, 2015, revealed that the resident was not using the device.

Interview with PSW #131 revealed that the resident never used the device and that he/she would never leave it on. He/she was capable of undoing the device. Interview with RPN #105 and RN #103 revealed that the resident very seldom used the device, only on those occasions when he/she was agitated, but that it was rare.

Interviews with RPN #105, RN #103 and the DOC confirmed that this was a potential source of confusion with respect to direction provided in the written plan of care. [s. 6. (1) (c)]

3. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other 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.

On July 23, 2015, observations revealed resident #005 sitting in his/her wheelchair with the lap belt fastened. On July 29, 2015, observations revealed the resident was with a private caregiver and sitting in a wheelchair in the dining room in a tilted position with the lap belt fastened. Later the same day, the resident was sitting in a wheelchair throughout an activity in a tilted position without having the lap belt fastened and being monitored by PSW #120.

Interview with private caregiver #119 revealed resident #005 used a lap belt and was tilted in the wheelchair to prevent sliding. Interview with PSW #120 revealed the seat belt was for when the resident was eating and the tilted chair was for when he/she was sitting or being wheeled around. According to registered staff #121 and 122 the lap belt was to be used when resident #005's wheelchair was not tilted and the wheelchair was to be tilted when the resident was sitting and relaxed.

Review of the resident's most recent plan of care revealed the resident used a personal assistive service device (PASD) in the form of a tilted wheelchair or lap belt for positioning and comfort. Review of an initial PASD assessment dated October 14, 2014, indicated the resident required the use of a lap belt or tilted wheelchair to prevent the

resident from sliding out of the wheelchair especially during locomotion.

Interview with the PT revealed that the use of a lap belt and tilted wheelchair for resident #005 was only for repositioning. The PT further stated that if the resident is left in a tilted wheelchair, it would not be a PASD but would be considered a restraint. On July 30, 2015, the PT, inspector and registered nurse #111 observed resident #005 in a common area sitting in a tilted wheelchair with no staff in attendance. Interview with RN #111 and the PT confirmed that the proper implementation of the PASDs for resident #005 needed to be clarified with staff and others who provided direct care. [s. 6. (4) (b)]

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

**Specifically failed to comply with the following:**

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Observations of resident #012 on July 22, 2015, revealed a lesion, of a specified dimension on the resident's body.

A review of the resident's chart revealed that the physician had assessed the lesion in March, 2014. In addition, a review of the resident's assessments revealed that the resident had a similar lesion on another part of her body, which is assessed weekly.

Interview with RPN #117 revealed that the lesion in question was a very long-standing issue for the resident as it was initially assessed by the physician in March, 2014. It had been assessed and the physician had not ordered any treatment, aside from verbally stating that it should be monitored. RPN #117 confirmed that a skin assessment for this lesion had not been done.

Interview with the clinical coordinator confirmed that at the very least this lesion should have been assessed so that staff could monitor it's characteristics and confirmed that this hadn't been done. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff.

A review of the resident #008's progress notes and interview with the RN confirmed that the resident had an alteration in her skin integrity on a specified area of his/her body.

A review of the assessment records revealed that weekly wound assessments were not completed for the weeks of July 12-18 and July 26-August 1, 2015.

An interview with RN #103 confirmed that a weekly wound assessment was not conducted for resident #008. [s. 50. (2) (b) (iv)]

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

**Specifically failed to comply with the following:**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures are implemented to ensure that the plumbing fixtures are maintained.

Observations on July 24, 27, 29, 2015, revealed a leaking faucet in the shared washroom in room 210. It was also observed that on July 28, 2015, there was a faucet in the washroom of room 214 that had no stop point.

Interview with the EM revealed that all staff are to report in the maintenance binder any faulty or leaking faucets. Interview and observations with the EM confirmed that the leaking and faulty faucets in washrooms in rooms 210 and 214 had not been reported to maintenance and had not therefore been maintained. [s. 90. (2) (d)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that direct care staff are provided annual training in the application, use and potential dangers of PASDs.

Record review and interview with the clinical coordinator revealed that 35 percent of direct care staff had not received training in 2014-2015 in the above noted areas. [s. 221. (1) 6.]

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**Issued on this 17th day of November, 2015**

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

**Original report signed by the inspector.**