Ontario

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 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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419, rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 9, 2019	2019_717531_0014	000268-18, 009941-18, 010454-18, 014431-18, 014625-18, 015849-18, 016578-18, 019261-18, 019423-18, 027668-18, 029899-18, 030943-18	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 Guildwood
60 Guildwood Parkway SCARBOROUGH ON M1E 1N9

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

SUSAN DONNAN (531), EMILY BROOKS (732), LINDA HARKINS (126), LYNE DUCHESNE (117)

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): June 10, 11, 12, 13, 17,18 and 19, 2019.

The following logs were inspected concurrently during this inspection:
Log #030943-18 related to sufficient staff
Log #000268-18 related to sufficient staff
Log #015849-18 related to safe and secure home
Log #019261-18 related to care and services
Log #029899-18 related to care and services
Log #019423-18 related to sufficient staff
Log #016578-18 related to pain management
Log #027668-18 related to care and services
Log #009941-18 related to sufficient staff
Log #014431-18 related to care and services
Log #010454-18 related to sufficient staff
Log #014625-18 related to sufficient staff

During the course of the inspection, the inspector(s) spoke with The two Directors of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), the Physiotherapist (PT), a Maintenance Worker (MW), the Environmental Services Supervisor (ESS), and the Nursing Clerk (NC).
During the course of the inspection the inspectors conducted a walking tour of the home, observed resident care and services, reviewed resident health care records, reviewed preventative maintenance process and records, reviewed the registered staff rotation schedules, resident medication administration records and medication incident reports.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

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

- **2 WN(s)**
- **1 VPC(s)**
- **1 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber for resident's #004, #005 and #007.

Several anonymous complaints were received related to the shortage of a Registered Nurse (RN) on the night shift and resulted in some residents not being administered their medications. The RN Rotation Schedules were reviewed for the identified period of time. It was noted that during that period, there was one night shift (2300-0700 hours) on a identified date that there was only one RN on site.

The Medications Administration Record (MARs) were reviewed specifically for the identified date (0600 hours) and it was noted that for the three randomly chosen residents (# 004, #005, and #007) that the residents did not received their 0600 hour and 0630 hours medications.

Resident #004's MAR for the identified date the physician had ordered the resident be administered a medication daily at 0600 hours.
Resident #005's MAR for the identified date the physician had ordered the resident be administered a medication daily at 0600 hours.
Resident #007's MAR for the identified date, the physician had ordered the resident be administered a medication daily at 0630 hours.

A review of the identified date MARs for all three residents indicated that the 0600 hours and 0630 hours dose of the scheduled medication were not signed for.

In an interview with Directors of Care (DOC) #102 and #103 on June 12, 2019, they indicated that they were aware that there was one RN on the night shift of the identified date. DOC #103 indicated that they were probably made aware during the morning report that the 0600 hours and 0630 hours medications were not administered to the residents on the East Wing.

The licensee failed to ensure that on a identified date, resident #004, #005 and #007 received their 0600 hours and 0630 hours medications as per the prescriber's orders.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure the medication incident involving resident #004, #005 and 007 was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Resident #004, 005 and #007 were not given their 0600 hour and 0630 hour medication on a identified date.

In an interview with the Directors of Care (DOC) #102 and #103 on June 12, 2019, they indicated that they were aware that there was one RN on the identified date. DOC #103 indicated that they were probably made aware during the morning report that the 0600 hours and 0630 hours medications were not administered to the residents on the East Wing. Both DOCs indicated that on the identified date, the registered nursing staff on the day shift did not administered the morning medication to those residents on the East Wing nor were they directed to do so.

DOC #103 indicated that it is expected that when there is a missed medication, an internal Medication Incident Report (MIR) shall be completed and the policy (Medication Incident Reporting, 9-1, revised 1/19) requirements shall be implemented. In reviewing the identified date MIRs with DOC #103, it was noted that there were no MIRs completed for resident # 004,#005 and #007 for the missed medications.

The licensee failed to complete MIR for resident #004, #005 and #007. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is immediately documented, together with a record of the immediate actions taken to assess the resident's health and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider., to be implemented voluntarily.

Issued on this 29th day of July, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) /
Nom de l'inspecteur (No) : SUSAN DONNAN (531), EMILY BROOKS (732), LINDA HARKINS (126), LYNE DUCHESNE (117)

Inspection No. /
No de l'inspection : 2019_717531_0014

Log No. /
No de registre : 000268-18, 009941-18, 010454-18, 014431-18, 014625-18, 015849-18, 016578-18, 019261-18, 019423-18, 027668-18, 029899-18, 030943-18

Type of Inspection /
Genre d'inspection: Complaint

Report Date(s) /
Date(s) du Rapport : Jul 9, 2019

Licensee /
Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9

LTC Home /
Foyer de SLD : Extendicare Guildwood
60 Guildwood Parkway, SCARBOROUGH, ON, M1E-1N9

Susanne Babic

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Name of Administrator / Nom de l’administratrice ou de l’administrateur :

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall be compliant with O. Reg 79/10, s. 131. (2)

Specifically, the licensee shall ensure that the 0600 and 0630 hours medications are administered to resident #004, #005 and #007 and to all other residents in accordance with the directions for use specified by the prescriber.

In order to ensure compliance, the licensee shall develop and implement monitoring and remedial processes to ensure medications are administered as per the prescriber's directions.

A written record of corrective action must be maintained.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber for resident's #004, #005 and #007.

Several anonymous complaints were received related to the shortage of a Registered Nurse (RN) on the night shift and resulted in some residents not being administered their medications. The RN Rotation Schedules were reviewed for the identified period of time. It was noted that during that period, there was one night shift (2300-0700 hours) on a identified date that there was only one RN on site.

The Medications Administration Record (MARs) were reviewed specifically for the identified date (0600 hours) and it was noted that for the three randomly chosen residents (# 004, #005, and #007) that the residents did not receive their

0600 hours and 0630 hours medications.

Resident #004's MAR for the identified date the physician had ordered the resident be administered a medication daily at 0600 hours.
Resident #005's MAR for the identified date the physician had ordered the resident be administered a medication daily at 0600 hours.
Resident #007's MAR for the identified date, the physician had ordered the resident be administered a medication daily at 0630 hours.

A review of the identified date MARs for all three residents indicated that the 0600 hours and 0630 hours dose of the scheduled medication were not signed for.

In an interview with Directors of Care (DOC) #102 and #103 on June 12, 2019, they indicated that they were aware that there was one RN on the night shift of the identified date. DOC #103 indicated that they were probably made aware during the morning report that the 0600 hours and 0630 hours medications were not administered to the residents on the East Wing.

The licensee failed to ensure that on a identified date, resident #004, #005 and #007 received their 0600 hours and 0630 hours medications as per the prescriber's orders.

(126)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 06, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of July, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Susan Donnan

Service Area Office /
Bureau régional de services : Central East Service Area Office