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
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée 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
Nov 25, 2019	2019_702197_0025 (A1)	006286-19, 006287-19, 006288-19, 014344-19, 014973-19, 016255-19, 017120-19, 017874-19	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

Amended by JESSICA PATTISON (197) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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*

This report has been amended to reflect the wording change of a job title, as requested by the licensee.

Issued on this 25th day of November, 2019 (A1)

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

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
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Amended Public Copy/Copie modifiée 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
Nov 25, 2019	2019_702197_0025 (A1)	006286-19, 006287-19, 006288-19, 014344-19, 014973-19, 016255-19, 017120-19, 017874-19	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

Amended by JESSICA PATTISON (197) - (A1)

Amended 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 28-31,

November 1, 5, 6, 2019

The following logs were inspected as part of this report:

006286-19 - Follow-up to CO#003 from inspection #2019_414110_0003 regarding r. 8. (1), CDD Jul 31, 2019

006287-19 - Follow-up to CO#001 from inspection #2019_414110_0003 regarding s. 6. (7), CDD Jul 31, 2019

006288-19 - Follow-up to CO#002 from inspection #2019_414110_0003 regarding s. 19. (1), CDD Jul 31, 2019

014344-19 - Complaint related to a bed refusal

014973-19 - Follow-up to CO#001 from inspection #2019_717531_0014 regarding r. 131. (2), CDD Sep 06, 2019

016255-19 - Complaint related to staffing and medication administration

017120-19 - Complaint related to Registered Nurse (RN) staffing

017874-19 - Complaint related to availability of supplies, bathing, nursing and personal support services and plan of care

This report also contains a finding from inspection # 2019_702197_0026 / log 014412-19 related to CI # 2164-000036-19. (CO #001 to s. 6(1)c)

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Quality Risk Management Coordinator, the Physiotherapist, the Dietary Manager, the Housekeeping Supervisor, Housekeeping Staff, a Cook, Laundry staff, Restorative Care staff, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspectors reviewed relevant policies and procedures, resident health care records, audits related to falls, a binder of shift report statements, RN schedules, a bed refusal letter, a critical incident report and observed resident care and specific areas of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Admission and Discharge
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **3 VPC(s)**
- **4 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
O.Reg 79/10 s. 131. (2)	CO #001	2019_717531_0014	531
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2019_414110_0003	531
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_414110_0003	197

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 following non-compliance is related to log 014412-19.

The licensee has failed to ensure that the plans of care for residents #002 and 006 set out clear directions for staff and others who provide direct care to the residents.

Resident #002 had a fall and sustained an injury. Upon review of the incident, the inspector noted that the resident's plan of care was updated the day of the fall to include a specified intervention.

The inspector made observations and did not see the specified intervention in place. During an interview with RPN #108, they stated that resident #002 did not have the intervention. They stated that they recalled it was put in place for a period of time, but thought the staff had reassessed and determined the intervention was not required. The inspector reviewed the progress notes but was unable to find any discussion / assessment for the use of the intervention for resident #002.

At a later date in the inspection, the DOC informed the inspector that they had spoken to RPN #108 and they indicated that they had updated the plan of care to reflect that the intervention was not required for resident #002.

Therefore, at the time of the inspection, the plan of care for resident #002 did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. The following non-compliance is related to log 006286-19.

Resident #006 was identified at high risk for falls with their most recent fall occurring on a specified date. The resident's current plan of care related to falls prevention directed staff to assess for appropriate use of specified interventions and to use precautions for falling.

On the day of the resident's last fall, PSWs found resident #006 laying on the floor on their stomach and noted a large amount of blood. The resident was noted to be confused and agitated and appeared to have been trying to get out of bed. The resident was then sent out to hospital for further assessment and returned the next day. A few days later, the resident was re-admitted to the hospital. The resident was then discharged to palliative care and did not return to the home.

Upon review of the Post-Fall Assessment for this fall, RPN #121 documented under the section "describe how the fall may have been prevented", specified interventions.

During an interview with RPN #121, they indicated that the resident was awake most of the night before they fell and the staff spent quite a bit of time trying to settle the resident back to bed. When asked if there was a specified intervention in place for the resident, the RPN said no.

PSW's #122 and #123 also worked the night shift when the resident fell and stated that there was no specified intervention in place when the resident fell. PSW #122 stated that they were alerted to the resident's room when they heard them calling out and the resident was on the floor when they found them.

During an interview with the Director of Care, they indicated that the resident did have the specified intervention and that it should have been in place at the time of the fall. When asked, the DOC could not say how long the intervention had been in place for the resident.

The Physiotherapist was interviewed and reviewed their notes/recommendations with the inspector related to the resident's falls. On three specified dates, the Physiotherapist recommended that the resident use another type of intervention, each after a fall that had occurred. When asked if they had ever recommended the use of the other specified intervention or if the resident had one, the

Physiotherapist stated that they could not see in their notes where they had recommended one, but indicated that it would have been standard for a resident such as resident #006 and indicated they should have had one in place.

RPN #124 and PSW #126, both regular evening staff, indicated to the inspector in interviews that resident #006 did use the specified intervention, but they did not recall the use of the other type of intervention that was suggested by the Physiotherapist.

Review of the progress notes for resident #006 for a two month period showed no mention of the use of the specified intervention until after the resident's most recent fall. There was also no mention of the use of the other type of intervention, although the Physiotherapist wrote a progress note 3 days after the last fall, recommending to continue the use of the intervention.

Based on what the inspector found, the written care plan for resident #006 did not indicate that either intervention should be used for the resident. According to the Physiotherapist, both should have been in place. The DOC indicated the one specified intervention should be in place. Evening staff indicated that the specified intervention was in place, but that they other type was not. Night staff indicated that the specified intervention was not in place. Therefore, the plan of care related to the use of fall prevention interventions for resident #006 did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The following finding is related to log 017120-19.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

In accordance with s.8(3) of the LTCHA 2007, the licensee was required to ensure that there was at least one registered nurse on duty and present in the home at all times. The Long-term Care Home is a 169 bed home divided into two units.

During an interview with Inspector #641, the DOC indicated that as per the licensee's staffing plan, there should be two RN's in the building on each shift. When an RN was not available for a shift, another RN would be called in and overtime would be offered when needed. If an RN was available for the shift, an RPN would be called in to replace the one RN. The DOC stated that if no RN were available for the shift, then one of the Directors of Care would come in to act as the RN in the home.

Inspector #641 reviewed the registered staff attendance sheets for a specified period with the DOC. The inspector found and the DOC confirmed, that there were no RN's on duty and present in the Long-Term Care home for 11 evening shifts.

The licensee failed, on eleven evening shifts over a four month period, to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff, was on duty and present at all times in the home. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

This inspection was conducted in reference to complaint intake log #017874-19, indicating that residents were not always getting bathed on a regular basis.

During an interview with Inspector #641, resident #011 indicated they didn't get two showers per week consistently. Resident #011 stated there were many times they wouldn't get showered because the staff were working short and they didn't have time to do it. The resident indicated they were not given a bed bath or offered a shower the next day but would instead have to wait until their next scheduled shower day.

During an interview with Inspector #641, resident #008 indicated they were to receive two showers per week but often didn't get them both. Resident #008 indicated they get about one shower per week on average. The resident stated they received a bed bath a few times instead of a shower, but this was not okay with the resident because they preferred to have showers.

Inspector #641 reviewed a random selection of residents' health care records, specifically the point of care (POC) charting indicating when a resident was bathed in the last 14 day look back period.

The inspector found that six residents had no documentation for 1, 2 or 4 of their 4 scheduled showers/baths in the 2 week period. There was no further documentation of showers/bed baths being offered or any indication that these residents had refused.

PSWs #102, 103, 111 and RN #104 were interviewed related to bathing. Collectively, they indicated that each resident was scheduled to have two showers per week, one on the day shift and the other would be on the evening shift. When asked by the inspector if there were times that a resident wouldn't get a shower, they stated that if they were short-staffed, some residents might not get their shower and would only get one that week. The staff also indicated the tub on the unit didn't work and stated that all residents get either a shower or a full bed bath, and if a resident requests a bath, they would offer a shower instead.

During an interview with inspector #641, the Director of Care (DOC) stated that when the staff were working short, that would mean that each PSW working would have a larger number of residents to attend to. The policy of the home was that if they were unable to get a shower done for a resident, they would offer a bed bath or reschedule the shower for the next shift or the next day. The DOC advised being aware there were two tub baths in the building and that they weren't being used at present. The DOC stated that they were planning to review the residents' care plans for preferences to offer those residents who wanted a tub bath, at least one per week.

During a meeting with Inspector #641, Inspector #197, the Administrator (Admin) and DOC, the Admin indicated that both of the tubs in the home were in working order. The DOC advised that the tubs were currently not available for the residents to have a tub bath due to the equipment stored around them.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice. [s. 33. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 following non-compliance is related to log 006286-19.

Compliance Order #003 was issued to the licensee on March 8, 2019 under inspection # 2019_414110_0003 with a compliance due date of July 31, 2019.

The compliance order was issued to O. Reg. 79/10, s. 8(1) and asked that the licensee do the following:

The licensee must be compliant with O. Reg. 79/10, s. 8(1).

The licensee is ordered to:

1. Ensure, by way of the registered staff signature, that all registered staff are educated of the requirements in the homes' policy entitled “Falls Prevention and Management Program”; policy number RC-15-01-01; Last updated: February 2017, specifically Post Fall Management and the “Clinical Monitoring Record V-3 Q 1 hr Neuro Check” and what steps needs to be taken and when.

2. Educate registered staff on the initial physical and neurological assessments and through the signing of a signature, ensure all registered staff are knowledgeable in completing the pupil assessment and Glasgow Coma Scale, components of the homes' “Clinical Monitoring Record".

3. Educate all registered staff on the nursing care requirements when a resident presents with a change in status and has a Level 1 Medical Directive.

4. Include a review of the home's policy related to Fall Prevention and Management, including the pupil assessment and Glasgow Coma Scale assessment in the Orientation and Training of all newly hired registered staff.

5. The DOC will audit every unwitnessed fall in the home for at a minimum of a 6 month period to ensure that the home's policy had been adhered to.

6. The audits shall include but not be limited to the completion of the Clinical Monitoring Record, Post Fall Assessment Tool and Huddle, Notification of POA/SDM/family, Physician/NP and the management of resident's pain.

7. A record shall be kept of all steps 1-6 and the audits, including the follow-up action taken should the policy not be followed by a registered staff for review by an Inspector.

Upon inspection, the licensee was found to be compliant with steps 1-5 and non-compliant with steps 6 and 7.

The licensee did not comply with step 6 in that the audits completed did not all include information regarding the notification of the POA/SDM/family and Physician/NP, and there was no information recorded in the audit related to the management of the residents’ pain.

The licensee did not comply with step 7 in that for the audits completed for a

specified time period, there was no record kept of the follow-up actions taken when registered staff did not follow the Falls Prevention and Management Program.

The licensee was also found to be non-compliant with their Falls Prevention and Management Program RC-15-01-01, last updated August 2019.

According to Ontario Regulation (O. Reg.) 79/10, s. 8(1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

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.

Appendix 6 of the licensee's Falls Prevention and Management Program is the Clinical Monitoring Record. The Clinical Monitoring Record is to be completed if a resident hits their head or is suspected of hitting their head (eg. an unwitnessed fall). The Clinical Monitoring Record directs staff to do the following:

Monitor the following every hour x 4 hours then every 8 hours x 72 hours:
- Neurovital signs (if head/brain injury suspected or the fall is unwitnessed)
- Monitor vital signs
- Assess for pain
- Monitor for changes in behaviour

During an interview with the DOC, they indicated that the staff document each assessment electronically in PointClickCare. A completed Clinical Monitoring Record will have 13 completed assessments – 1 every hour for the first 4 hours and then 1 per 8 hour shift over a three day period (72 hours).

The inspector randomly selected residents who had falls in a certain time period where the Clinical Monitoring Record was to be completed since the resident had either hit their head or were suspected to have hit their head.

Resident #008 had a fall and indicated to staff that they had hit their head. Upon review of the Clinical Monitoring Record, the inspector found that 1 out of 4 hourly

assessments was not completed and 2 out of 9 eight hour assessments were not completed.

Resident #009 had an unwitnessed fall. Upon review of the Clinical Monitoring Record, the inspector found that 1 out of 4 hourly assessments was not completed and 4 out of 9 eight hour assessments were not completed.

Resident #010 had an unwitnessed fall. Upon review of the Clinical Monitoring Record, the inspector found that 4 out of 4 hourly assessments were not completed and 2 out of 9 eight hour assessments were not completed.

The licensee did not comply with their Falls Prevention and Management Program, specifically the completion of the Clinical Monitoring Record, for residents #008, 009 and 010. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

This inspection was conducted in reference to an anonymous complaint, log 017120-19, indicating that a specified room and the showers on a specified unit were dirty.

Inspector #641 completed a tour of the home with specific notice of the shower rooms and a resident room. In the resident's room, behind the resident's bed by the window, there was an area approximately 10cm wide that stretched from the window wall to the middle of the room, that had a buildup of reddish-brown matter crusted on the floor. There were two blankets bunched up on the floor covering parts of the stained area. In a specified shower room, the wall tiles had a buildup of a dark brown matter between the grout lines. The floor grout line around the perimeter of the room had a dark brown build up measuring between 1.5 to 2 cm wide. The floor tiles around the shower drain had wide grout lines with a dark buildup. There were two areas around the drain with chipped and missing tiles. There were cracked tiles at the base of the shower head wall. In another shower room, the wall tiles had a buildup of a dark brown matter between the grout lines. The floor grout line around the perimeter of the room had a dark build up measuring between 1.5 to 2 cm wide. There were cracked tiles at the base of shower head wall.

During an interview with Inspector #641, the Support Services Manager #120 (SSM) indicated that the staining on the floor in the resident's room was due to a water leak that they had been investigating. The SSM stated they had not been able to identify were the leak was coming from. At the time of the interview, there was water observed on the floor behind the bed by the window, with a blanket spread out on the floor against the wall. The SSM advised that the blanket was placed there to help absorb the water that was seeping through the wall. The SSM stated that they would be continuing to seek out an answer to why the water was leaking into this room and staining floor tiles behind the bed.

The Inspector and the SSM observed the shower rooms on a particular unit. The SSM stated that they had a steamer with tool heads to remove the buildup of dirt between the tiles. The SSM indicated that the expectation was that the housekeeping staff would use the steamer tool approximately every two weeks to remove any buildup on the tiles. The SSM stated they would have the

housekeeper who was trained to use the steamer start working on removing the dirt in the showers. The SSM advised that the tiling in the shower rooms were going to be redone.

During an interview with Inspector #641, housekeeper #113 advised that when the buildup was noticed on the tiles in the showers, they used the steamer to help remove it. Housekeeper #113 stated they would make time to remove the buildup in these areas.

The licensee failed to ensure that the walls and flooring in the showers on a specified unit and a resident's room were kept clean and sanitary. [s. 15. (2) (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 that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day of an incident that caused a significant injury to resident #006, for which they were taken to a hospital and that resulted in a significant change in the resident's health condition.

On a specified date, resident #006 had an unwitnessed fall in their room. When the resident was found they were noted to be laying on their stomach on the floor with a head injury. Registered staff assessed the resident and they were sent to the hospital for further assessment.

Resident #006 was sent back to the home the following day and was noted to be weak, lethargic and congested. Progress notes also indicated the resident had sutures and swelling.

Two days after the fall, resident #006 was noted to require a specified intervention. The resident was also noted to be sleepy and did not eat breakfast or lunch. The following day, the resident again required a specified intervention.

Four days after the fall, resident #006 was noted to have a decreased level of consciousness and was sent back to hospital for assessment. The resident was noted to be admitted to the hospital and was deemed palliative.

Three days later, the resident's spouse confirmed that the home could discharge the resident as they would not be returning.

The inspector reviewed the Critical Incident System and did not find a report submitted to the Director related to the fall and significant change in resident #006's health condition.

During an interview with the DOC, they confirmed that the home did not submit a Critical Incident Report to the Director regarding resident #006's fall. [s. 107. (3) 4.]

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 Director is informed within one business day of any incident that causes a significant injury to a resident, for which they are taken to the hospital and that results in a significant change in their health condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director of Nursing and Personal Care in the long-term care home worked regularly in that position on site for at least 35 hours per week as required in a long-term care home with more than 65 beds.

During an interview with Inspector #641, the Director of Care (DOC) stated that if no Registered Nurse (RN) were available to work a shift, then one of the Directors of Care would come in to act as the RN in the home. The DOC stated that any shifts that the DOC worked as the RN on the floor, would be taken off from the scheduled DOC time, as a lieu day. The DOC indicated that since there is only one DOC currently in the home, there was no one available to replace the DOC for the hours that were taken in lieu for working the RN shifts.

Inspector #641 reviewed the registered staff attendance sheets for a specified time period with the DOC. The DOC advised the Inspector of having worked in the building as the RN on two night shifts and that they would be taking two days off from the DOC scheduled hours.

The licensee failed to ensure that the DOC worked regularly in that position on site for at least 35 hours per week. [s. 213. (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 the Director of Nursing and Personal Care in the long-term care home works regularly in that position, on site, for at least 35 hours per week, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The licensee failed to provide a written notice setting out a detailed explanation of the supporting facts, as they related both to the home and to the applicant's condition and care requirements, when the licensee withheld approval for admission for applicant #027.

An inspection was conducted for intake #014344-19 regarding the withheld approval for admission for applicant #027. The written notice read that the home lacked the physical facilities necessary for care.

During an interview with the Administrator, review of the applicant's application and the licensee's written notice withholding approval for admission, the Administrator told inspector #531 that the written notice did not provide a detailed explanation of the supporting facts, as they related to both the home and applicant #027's condition.

The licensee failed to provide a written notice setting out a detailed explanation of the supporting facts, as they related to both the home and the applicant's condition when withholding approval for admission. [s. 44. (9) (b)]

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA:

It is a condition of every licence that the licensee shall comply with every order made under this Act.

On March 8, 2019, Compliance Order (CO) #001 from inspection number 2019_414110_0003 was made under LTCHA, 2007 S.O. 2007, c. 8, s. 6(7) and stated:

The licensee must be compliant with the LTCHA, 2007, s. 6(7).

The licensee was ordered to:

1. Educate all direct care staff, including registered staff, on the risks associated with residents using furniture as ambulatory aids and not implementing the plan of care while sharing the MOHLTC inspection report leading up to the critical incident involving resident #001's fall.

2. At every shift report, for a minimum of a one year period, registered staff shall remind PSWs of the requirement to ensure resident's who ambulate with mobility aids are provided with the mobility aids in keeping with the resident's written plan of care.

3. A record shall be kept of steps #1 and #2.

The compliance due date was July 31, 2019.

The licensee complied with step 1 of the compliance order in that they provided evidence that all direct care staff, including registered staff, were educated on the risks associated with using furniture as ambulatory aids and were able to provide a record showing the education and those who attended.

The licensee failed to comply with parts of step 2 and 3, in that not all registered staff members responsible for reminding PSWs at shift report about the appropriate use of mobility aids signed that they completed the communication and for one date, only one shift report statement sheet could be found.

During the inspection, the Director of Care (DOC) gave the inspector a binder full of shift report statements and indicated there are two per date, one for the west and one for the east. Upon review of all the sheets provided, the following was found:
- There was only one shift report statement found for a specified date
- There were 23 evening, 6 day and 3 night shift charge nurse signatures missing for various dates

Therefore, the licensee did not comply with part of an order made under this Act. [s. 101. (3)]

Issued on this 25th day of November, 2019 (A1)

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA PATTISON (197) - (A1)
Inspection No. / No de l'inspection :	2019_702197_0025 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006286-19, 006287-19, 006288-19, 014344-19, 014973-19, 016255-19, 017120-19, 017874-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 25, 2019(A1)
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
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	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

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

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall be compliant with LTCHA 2007, s. 6 (1).

Specifically, the licensee shall ensure that the plan of care for all residents assessed at risk for falls (including residents #002 and 006 if applicable), in relation to falls prevention, sets out clear directions to staff and others who provide direct care to the resident by ensuring:

1) Consistent information throughout the plan of care that is understood and followed by direct care staff.
2) Revisions are based on a documented reassessment of a resident's condition/behavior and all changes are clearly documented and communicated to direct care staff.
3) When new fall prevention interventions are implemented, there is documentation to support the effectiveness and ongoing use or discontinuation of the interventions.

Grounds / Motifs :

1. The following non-compliance is related to log 014412-19.

The licensee has failed to ensure that the plans of care for residents #002 and 006 set out clear directions for staff and others who provide direct care to the residents.

Resident #002 had a fall and sustained an injury. Upon review of the incident, the inspector noted that the resident's plan of care was updated the day of the fall to include a specified intervention.

The inspector made observations and did not see the specified intervention in place. During an interview with RPN #108, they stated that resident #002 did not have the intervention. They stated that they recalled it was put in place for a period of time, but thought the staff had reassessed and determined the intervention was not required. The inspector reviewed the progress notes but was unable to find any discussion / assessment for the use of the intervention for resident #002.

At a later date in the inspection, the DOC informed the inspector that they had spoken to RPN #108 and they indicated that they had updated the plan of care to reflect that the intervention was not required for resident #002.

Therefore, at the time of the inspection, the plan of care for resident #002 did not set out clear directions to staff and others who provide direct care to the resident. (197)

2. The following non-compliance is related to log 006286-19.

Resident #006 was identified at high risk for falls with their most recent fall occurring on a specified date. The resident's current plan of care related to falls prevention directed staff to assess for appropriate use of specified interventions and to use precautions for falling.

On the day of the resident's last fall, PSWs found resident #006 laying on the floor on their stomach and noted a large amount of blood. The resident was noted to be confused and agitated and appeared to have been trying to get out of bed. The resident was then sent out to hospital for further assessment and returned the next day. A few days later, the resident was re-admitted to the hospital. The resident was then discharged to palliative care and did not return to the home.

Upon review of the Post-Fall Assessment for this fall, RPN #121 documented under

the section "describe how the fall may have been prevented", specified interventions.

During an interview with RPN #121, they indicated that the resident was awake most of the night before they fell and the staff spent quite a bit of time trying to settle the resident back to bed. When asked if there was a specified intervention in place for the resident, the RPN said no.

PSW's #122 and #123 also worked the night shift when the resident fell and stated that there was no specified intervention in place when the resident fell. PSW #122 stated that they were alerted to the resident's room when they heard them calling out and the resident was on the floor when they found them.

During an interview with the Director of Care, they indicated that the resident did have the specified intervention and that it should have been in place at the time of the fall. When asked, the DOC could not say how long the intervention had been in place for the resident.

The Physiotherapist was interviewed and reviewed their notes/recommendations with the inspector related to the resident's falls. On three specified dates, the Physiotherapist recommended that the resident use another type of intervention, each after a fall that had occurred. When asked if they had ever recommended the use of the other specified intervention or if the resident had one, the Physiotherapist stated that they could not see in their notes where they had recommended one, but indicated that it would have been standard for a resident such as resident #006 and indicated they should have had one in place.

RPN #124 and PSW #126, both regular evening staff, indicated to the inspector in interviews that resident #006 did use the specified intervention, but they did not recall the use of the other type of intervention that was suggested by the Physiotherapist.

Review of the progress notes for resident #006 for a two month period showed no mention of the use of the specified intervention until after the resident's most recent fall. There was also no mention of the use of the other type of intervention, although the Physiotherapist wrote a progress note 3 days after the last fall, recommending to continue the use of the intervention.

Based on what the inspector found, the written care plan for resident #006 did not indicate that either intervention should be used for the resident. According to the Physiotherapist, both should have been in place. The DOC indicated the one specified intervention should be in place. Evening staff indicated that the specified intervention was in place, but that they other type was not. Night staff indicated that the specified intervention was not in place. Therefore, the plan of care related to the use of fall prevention interventions for resident #006 did not set out clear directions to staff and others who provide direct care to the resident.

The decision to issue a compliance order was based on the scope, severity and compliance history of this non-compliance. There was actual harm to resident #006, as they sustained a head injury and within 1 week, was discharged from the home into palliative care. Two out of three residents reviewed lacked clear direction related to the use of specified interventions to help prevent falls and the licensee has a compliance history related to this section as follows:
- Inspection #2019_717531_0015 - VPC issued July 8, 2019
- Inspection #2018_594624_0009 - WN issued Sept 7, 2018 (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall be compliant with s.8(3) of the LTCHA, 2007.

Specifically, the licensee must ensure that at least one registered nurse who is an employee of the licensee or works at the home pursuant to a contract with the licensee and is a member of the regular nursing staff of the home, is on duty and present at all times.

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

Grounds / Motifs :

(A1)
1. The following finding is related to log 017120-19.

The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

In accordance with s.8(3) of the LTCHA 2007, the licensee was required to ensure that there was at least one registered nurse on duty and present in the home at all times. The Long-term Care Home is a 169 bed home divided into two units.

During an interview with Inspector #641, the DOC indicated that as per the licensee's staffing plan, there should be two RN's in the building on each shift. When an RN was not available for a shift, another RN would be called in and overtime would be offered when needed. If an RN was available for the shift, an RPN would be called in to replace the one RN. The DOC stated that if no RN were available for the shift, then one of the Directors of Care would come in to act as the RN in the home.

Inspector #641 reviewed the registered staff attendance sheets for a specified period with the DOC. The inspector found and the DOC confirmed, that there were no RN's on duty and present in the Long-Term Care home for 11 evening shifts.

The licensee failed, on eleven evening shifts over a four month period, to ensure that at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff, was on duty and present at all times in the home.

The decision to issue a compliance order was based on the scope, severity and compliance history of this non-compliance. There was potential for harm since the absence of a Registered Nurse potentially poses a risk to resident safety and affects every resident living in the home. The inspector determined the issue to be a pattern as there were a total of 11 shifts with no RN on duty in the home during the four month period reviewed. The licensee was issued a Voluntary Plan of Correction to the same section on May 7, 2018, under Inspection #2018_594624_0009. (641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 23, 2020

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

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 33(1).

The licensee shall ensure that every resident is bathed, by the method of his or her choice, at a minimum of twice per week.

Specifically, the licensee shall:
1) Ensure both registered and non-registered nursing staff take action when a bath/shower is not provided as scheduled to ensure that residents are offered another bathing option that is agreeable to them, before their next scheduled bath/shower.
2) Ensure each resident is offered a tub bath as a bathing option. Documentation is to be kept in the resident's health care record, of being offered the option of a tub bath and their selected preference.
3) Ensure all showers/baths are documented as given, refused, or rescheduled. All rescheduled baths shall be documented as to when they are given and by what bathing method.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

This inspection was conducted in reference to complaint intake log #017874-19, indicating that residents were not always getting bathed on a regular basis.

During an interview with Inspector #641, resident #011 indicated they didn't get two showers per week consistently. Resident #011 stated there were many times they wouldn't get showered because the staff were working short and they didn't have time to do it. The resident indicated they were not given a bed bath or offered a shower the next day but would instead have to wait until their next scheduled shower day.

During an interview with Inspector #641, resident #008 indicated they were to receive two showers per week but often didn't get them both. Resident #008 indicated they get about one shower per week on average. The resident stated they received a bed bath a few times instead of a shower, but this was not okay with the resident because they preferred to have showers.

Inspector #641 reviewed a random selection of residents' health care records, specifically the point of care (POC) charting indicating when a resident was bathed in the last 14 day look back period.

The inspector found that six residents had no documentation for 1, 2 or 4 of their 4 scheduled showers/baths in the 2 week period. There was no further documentation of showers/bed baths being offered or any indication that these residents had refused.

PSWs #102, 103, 111 and RN #104 were interviewed related to bathing. Collectively, they indicated that each resident was scheduled to have two showers per week, one on the day shift and the other would be on the evening shift. When asked by the inspector if there were times that a resident wouldn't get a shower, they stated that if they were short-staffed, some residents might not get their shower and would only get one that week. The staff also indicated the tub on the unit didn't work and stated that all residents get either a shower or a full bed bath, and if a resident requests a bath, they would offer a shower instead.

During an interview with inspector #641, the Director of Care (DOC) stated that when the staff were working short, that would mean that each PSW working would have a larger number of residents to attend to. The policy of the home was that if they were unable to get a shower done for a resident, they would offer a bed bath or reschedule the shower for the next shift or the next day. The DOC advised being aware there

were two tub baths in the building and that they weren't being used at present. The DOC stated that they were planning to review the residents' care plans for preferences to offer those residents who wanted a tub bath, at least one per week.

During a meeting with Inspector #641, Inspector #197, the Administrator (Admin) and DOC, the Admin indicated that both of the tubs in the home were in working order. The DOC advised that the tubs were currently not available for the residents to have a tub bath due to the equipment stored around them.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

The decision to issue a compliance order was based on the scope, severity and history of the non-compliance. There is potential for harm related to infection control and the personal hygiene of residents. The non-compliance was widespread as 8 out of 8 residents reviewed were affected and the fact that the home is not using their bath tubs is affecting all residents. The home was noted to have no compliance history specific to this legislation in the past 36 months.
(641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 24, 2020

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

Order # / Ordre no : 004

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

Linked to Existing Order / Lien vers ordre existant: 2019_414110_0003, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 8(1).

Specifically, the licensee shall ensure that when a resident falls and hits their head, or has an unwitnessed fall, that the Clinical Monitoring Record is completed as specified in the Falls Prevention and Management Program, RC-15-01-01.

Grounds / Motifs :

1. The following non-compliance is related to log 006286-19.

Compliance Order #003 was issued to the licensee on March 8, 2019 under inspection # 2019_414110_0003 with a compliance due date of July 31, 2019.

The compliance order was issued to O. Reg. 79/10, s. 8(1) and asked that the licensee do the following:

The licensee must be compliant with O. Reg. 79/10, s. 8(1).

The licensee is ordered to:

1. Ensure, by way of the registered staff signature, that all registered staff are educated of the requirements in the homes' policy entitled “Falls Prevention and Management Program”; policy number RC-15-01-01; Last updated: February 2017, specifically Post Fall Management and the “Clinical Monitoring Record V-3 Q 1 hr Neuro Check” and what steps needs to be taken and when.

2. Educate registered staff on the initial physical and neurological assessments and through the signing of a signature, ensure all registered staff are knowledgeable in completing the pupil assessment and Glasgow Coma Scale, components of the homes' “Clinical Monitoring Record".

3. Educate all registered staff on the nursing care requirements when a resident presents with a change in status and has a Level 1 Medical Directive.

4. Include a review of the home's policy related to Fall Prevention and Management, including the pupil assessment and Glasgow Coma Scale assessment in the Orientation and Training of all newly hired registered staff.

5. The DOC will audit every unwitnessed fall in the home for at a minimum of a 6 month period to ensure that the home's policy had been adhered to.

6. The audits shall include but not be limited to the completion of the Clinical Monitoring Record, Post Fall Assessment Tool and Huddle, Notification of POA/SDM/family, Physician/NP and the management of resident's pain.

7. A record shall be kept of all steps 1-6 and the audits, including the follow-up action taken should the policy not be followed by a registered staff for review by an Inspector.

Upon inspection, the licensee was found to be compliant with steps 1-5 and non-compliant with steps 6 and 7.

The licensee did not comply with step 6 in that the audits completed did not all include information regarding the notification of the POA/SDM/family and Physician/NP, and there was no information recorded in the audit related to the management of the residents’ pain.

The licensee did not comply with step 7 in that for the audits completed for a specified time period, there was no record kept of the follow-up actions taken when registered staff did not follow the Falls Prevention and Management Program.

The licensee was also found to be non-compliant with their Falls Prevention and Management Program RC-15-01-01, last updated August 2019.

According to Ontario Regulation (O. Reg.) 79/10, s. 8(1) b, Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

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.

Appendix 6 of the licensee's Falls Prevention and Management Program is the Clinical Monitoring Record. The Clinical Monitoring Record is to be completed if a resident hits their head or is suspected of hitting their head (eg. an unwitnessed fall). The Clinical Monitoring Record directs staff to do the following:

Monitor the following every hour x 4 hours then every 8 hours x 72 hours:
- Neurovital signs (if head/brain injury suspected or the fall is unwitnessed)
- Monitor vital signs
- Assess for pain
- Monitor for changes in behaviour

During an interview with the DOC, they indicated that the staff document each assessment electronically in PointClickCare. A completed Clinical Monitoring Record will have 13 completed assessments – 1 every hour for the first 4 hours and then 1 per 8 hour shift over a three day period (72 hours).

The inspector randomly selected residents who had falls in a certain time period where the Clinical Monitoring Record was to be completed since the resident had either hit their head or were suspected to have hit their head.

Resident #008 had a fall and indicated to staff that they had hit their head. Upon review of the Clinical Monitoring Record, the inspector found that 1 out of 4 hourly assessments was not completed and 2 out of 9 eight hour assessments were not completed.

Resident #009 had an unwitnessed fall. Upon review of the Clinical Monitoring Record, the inspector found that 1 out of 4 hourly assessments was not completed and 4 out of 9 eight hour assessments were not completed.

Resident #010 had an unwitnessed fall. Upon review of the Clinical Monitoring Record, the inspector found that 4 out of 4 hourly assessments were not completed and 2 out of 9 eight hour assessments were not completed.

The licensee did not comply with their Falls Prevention and Management Program, specifically the completion of the Clinical Monitoring Record, for residents #008, 009 and 010.

The decision to issue this compliance order is based on the severity, scope and compliance history of the non-compliance. There was potential for harm as residents #008, 009 and 010 either hit their head or had unwitnessed falls and were not assessed as per the licensee's policy. Three residents reviewed were affected by the non-compliance and the licensee has a compliance history to the same section as follows:
- Inspection # 2018_594624_0009 - VPC issued September 7, 2018
- Inspection # 2019_414110_0003 - CO issued March 8, 2019 (197)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019

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

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:

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

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 25th day of November, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PATTISON (197) - (A1)

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

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