Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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33, rue King Ouest, étage 4
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 23, 2021	2021_838760_0005	024549-20	Critical Incident System

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

JACK SHI (760)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 29, February 1, 10, 11, 2021 (conducted on-site); February 2, 3, 2021 (conducted off-site).

The following intakes were completed in this critical incident inspection:

A log was related to a fall.

A Complaints inspection #2021_838760_0004 was conducted concurrently with this Critical Incident Systems inspection.

During the course of the inspection, the inspector(s) spoke with Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers, Activity Aides, Environmental Services Manager (ESM), Registered Dietitian (RD), Physician and the Director of Care (DOC).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for residents #002 and #007.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention", dated December 2019. The policy states that when staff notice any residents on the floor, the nurse needs to be immediately informed. The policy also states that prior to the transfer of a resident from the floor, the resident needs to be assessed by the nurse.

A Critical Incident Systems (CIS) report was submitted by the home related to the improper treatment of resident #002 that resulted in an injury. According to the resident's progress notes, the RPN was called by a PSW to assess the resident due to their injuries and the resident stated to the RPN that they had sustained a fall. The PSW did not indicate any involvement in the resident's fall at that time to the RPN. The resident was eventually diagnosed with an injury. The PSW was interviewed by the inspector and stated the resident fell while they provided care to them. The PSW stated they had transferred the resident after they fell during their care without an assessment by a nurse. The PSW acknowledged that this was an unsafe transfer and the DOC added that this could have put the resident at risk for further injury. Furthermore, the PSW stated they delayed their reporting of the resident's fall to the RPN. The delay at reporting the falls incident that resulted in an injury and the transfer of this resident prior to an assessment conducted by the nurse put the resident at risk for development of further

injuries.

Sources: Resident #002's progress notes; Fall Prevention and Management Program Policy (dated December 2019); Interview with a PSW, the DOC and other staff. [s. 8. (1) (b)]

2. A review of the resident #007's progress notes indicated that they were found by a PSW lying on the floor. An interview with the RN indicated that the resident was already transferred from the floor when they came to assess the resident, after their fall. The PSW indicated that another PSW had told them to transfer the resident from the floor. The PSW stated the resident was manually transferred by themselves and the other PSW from the floor. The PSW acknowledged that this was an unsafe transfer because if the resident had an injury, the staff may have potentially further aggravated the injury by transferring the resident from the floor without a clinical assessment from the registered staff. There was a potential risk to the resident, as the PSWs did not follow the home's fall prevention policy to ensure that an assessment was completed by a nurse prior to transferring a resident from the ground. The transfer made by the PSWs in this incident put the resident at risk for injuries after their fall.

Sources: Resident #007's progress notes; Interviews with an RN, a PSW and other staff. [s. 8. (1) (b)]

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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a post fall assessment was completed for resident #002 after they fell.

A CIS report was submitted by the home related to a fall of a resident that resulted in an injury. The home's fall prevention policy indicates that a post fall assessment tool is to be completed after a resident sustains a fall. A review of the resident's chart on Point Click Care (PCC) did not produce a post falls assessment related to this fall. The RN had reviewed their documentation and could not produce a completed post falls assessment tool that the home uses after a resident sustains a fall. There was potential risk to the resident as they sustained a fall with an injury and a post falls assessment tool that the home used, was not completed to assess the resident further.

Sources: Resident #002's progress notes and chart; Fall Prevention and Management Program Policy (dated December 2019); Interview with RN #110 and other staff. [s. 49. (2)]

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 when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

Issued on this 26th day of February, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JACK SHI (760)
Inspection No. / No de l'inspection :	2021_838760_0005
Log No. / No de registre :	024549-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 23, 2021
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 :	Deslyn Willock

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 # / No d'ordre : 001

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

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 must be compliant with s. 8 (1) (b) of O. Reg 79/10.

Specifically, the licensee shall:

1). Educate PSW #113 and PSW #114 to ensure they are familiar their responsibilities with what to do when they find a resident who has sustained a fall.

2). Keep a documented record of the education provided.

Grounds / Motifs :

1. The licensee has failed to ensure the falls prevention policies and procedures included in the required Falls Prevention Program were complied with, for residents #002 and #007.

In accordance with O.Reg. 79/10, s. 48(1), the licensee was required to ensure that that a falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented.

Specifically, staff did not comply with the home's policy and procedure "Falls Prevention", dated December 2019. The policy states that when staff notice any residents on the floor, the nurse needs to be immediately informed. The policy also states that prior to the transfer of a resident from the floor, the resident

needs to be assessed by the nurse.

A Critical Incident Systems (CIS) report was submitted by the home related to the improper treatment of resident #002 that resulted in an injury. According to the resident's progress notes, the RPN was called by a PSW to assess the resident due to their injuries and the resident stated to the RPN that they had sustained a fall. The PSW did not indicate any involvement in the resident's fall at that time to the RPN. The resident was eventually diagnosed with an injury. The PSW was interviewed by the inspector and stated the resident fell while they provided care to them. The PSW stated they had transferred the resident after they fell during their care without an assessment by a nurse. The PSW acknowledged that this was an unsafe transfer and the DOC added that this could have put the resident at risk for further injury. Furthermore, the PSW stated they delayed their reporting of the resident's fall to the RPN. The delay at reporting the falls incident that resulted in an injury and the transfer of this resident prior to an assessment conducted by the nurse put the resident at risk for development of further injuries.

Sources: Resident #002's progress notes; Fall Prevention and Management Program Policy (dated December 2019); Interview with a PSW, the DOC and other staff. (760)

2. A review of the resident #007's progress notes indicated that they were found by a PSW lying on the floor. An interview with the RN indicated that the resident was already transferred from the floor when they came to assess the resident, after their fall. The PSW indicated that another PSW had told them to transfer the resident from the floor. The PSW stated the resident was manually transferred by themselves and the other PSW from the floor. The PSW acknowledged that this was an unsafe transfer because if the resident had an injury, the staff may have potentially further aggravated the injury by transferring the resident from the floor without a clinical assessment from the registered staff. There was a potential risk to the resident, as the PSWs did not follow the home's fall prevention policy to ensure that an assessment was completed by a nurse prior to transferring a resident from the ground. The transfer made by the PSWs in this incident put the resident at risk for injuries after their fall.

Sources: Resident #007's progress notes; Interviews with an RN, a PSW and

other staff.

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the residents because a resident's fall was not immediately reported to a registered staff after it had happened and two residents were found to have been transferred prior to an assessment by a registered staff. One resident was diagnosed with an injury after their fall.

Scope: The scope of this non-compliance was a pattern because two of the three resident falls reviewed indicated that staff were not following the home's policy on fall prevention.

Compliance History: In the last 36 months, the licensee was found to be noncompliant with s. 8 (1) (b) of O. Reg 79/10, and five WNs, three VPC's, and two CO's, were issued to the home. (760)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 16, 2021

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 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 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 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 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 23rd day of February, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Jack Shi

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