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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 10, 2022	2022_882760_0006	016274-21, 019232-21, 001666-22, 002280-22, 002745-22	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), ERIC TANG (529)

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): February 28, March 1, 2, 3, 4, 8, 2022.

The following intakes were completed in this critical incident inspection:

A log was related to a fall;
A log was related to an allegation of staff to resident abuse;
A log was related to an allegation of staff to resident neglect;
A log was related to an allegation of staff to resident neglect and significant change in condition;
A log was related to an injury of an unknown cause.

During the course of the inspection, the inspector(s) spoke with the Registered Dietitian (RD), the Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), the Behavioural Supports Ontario Registered Practical Nurses (BSO RPN), Personal Support Workers (PSW), security guards, the Assistant Administrator and the Interim Director of Care (DOC).

During the course of the inspection, the inspector toured the home, observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

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

- **5 WN(s)**
- **5 VPC(s)**
- **0 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the resident was treated with courtesy and respect and in a way that fully recognizes their individuality and respects their dignity.

A record review indicated the resident exhibited responsive behaviours and resulted in an incident occurring in the facility.

An interview with the BSO Nurse confirmed the resident received an inappropriate intervention from the staff. The Acting Director of Care confirmed that as a result of this inappropriate intervention, the resident was not treated with courtesy, respect, and dignity.

Sources: Critical Incident Report, a resident's electronic health records, home's internal investigative records, and staff interviews. [s. 3. (1) 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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that an intervention was provided to the resident as specified in their plan of care.

Record reviews indicated that an intervention was initiated for the resident. The resident had experienced a fall, but the intervention was not utilized at that time.

An interview with the Acting Director of Care confirmed that the resident should have received the intervention as required in their plan of care.

Sources: Critical Incident Report, a resident's electronic health records, home's internal investigative records, and staff interviews. [s. 6. (7)]

2. The licensee failed to ensure that a resident's plan of care was revised to reflect their falls prevention interventions, when they were identified to become no longer necessary.

A review of their care plan indicated that following a resident's fall, they received a new falls prevention intervention. An observation was conducted and demonstrated that they were not using the intervention. A PSW stated this resident did not need this intervention and does not recall why it was in the resident's plan of care. The Interim DOC stated that staff should have removed this intervention from the resident's plan of care if it was determined that the intervention was not necessary. Failure to keep an accurate plan of care that reflects the resident's needs may result in unclear directions to staff members who are unfamiliar with the resident.

Sources: A resident's plan of care; An observation with the resident; Interview with a PSW, the Interim DOC and other staff. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 that head injury routine as indicated in home's Neurological Signs/Head Injury Routine policy was compiled with the resident.

Ontario Regulation 79/10, s. 49 (1) requires the licensee to have a falls prevention and management program that includes strategies to mitigate falls, including the monitoring of residents.

The home's Neurological Signs/Head Injury Routine policy indicated that a head injury routine (HIR) to be completed when a resident experiences an unwitnessed fall by the registered staff. A review of the records indicated the resident had experienced an unwitnessed fall.

An interview with the Acting Director of Care confirmed that the HIR was not completed and should have been completed in order to capture the resident's condition after the fall.

Sources: Critical Incident Report, a resident's electronic health records, home's internal investigative records, home's policy titled, Neurological Signs/Head Injury Routine, and staff interviews. [s. 8. (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 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, (b) is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that two resident's wounds were assessed weekly.

A review of the resident's progress notes indicated that the resident developed a wound. A review of skin and wound assessments indicated that the resident did not receive a weekly wound assessment from the registered staff on two occasions. RPN #109 had stated that they were assigned to conduct the weekly wound assessment for one of those occasions but did not recall why they did not complete it. RPN #110 stated they believed that the RN was responsible for completing the weekly wound assessment that was scheduled for another occasion, but the RN did not recall completing this assessment because they believed that it was the RPN's responsibility. The Interim DOC confirmed that during the home’s investigation into the allegation, they had identified incomplete weekly wound assessments as well and that education will be provided to the registered staff to reinforce the requirements related to weekly wound assessments.

Sources: Review of resident’s progress notes, completed skin and wound assessments on PointClickCare; Interviews with two RPNs, an RN, the Interim DOC and other staff. [s. 50. (2) (b) (iv)]

2. A resident's care plan had indicated that they had developed a wound. A review of the weekly skin and wound assessments indicated that they did not receive a weekly assessment on two occasions by a registered staff, with no further information documented in their progress notes. The Interim DOC confirmed that these weekly skin and wound assessments were not completed when it was scheduled for them to be completed.

Failure to monitor and assess the resident's wound may have resulted in missed opportunities to implement effective interventions to heal the resident’s wound.

Sources: Review of resident’s care plan, progress notes, completed skin and wound assessments on PointClickCare; Interview with the Interim DOC. [s. 50. (2) (b) (iv)]

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 that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, implementing interventions for the resident.

As per the record reviews, the resident was admitted to the Long-Term Care (LTC) facility with multiple health conditions and a review of external resident records indicated a history of responsive behaviours. Responsive behaviours continued to occur after admission and an intervention was initiated a few days later to better support the resident.

Several days after admission, the resident's responsive behaviours changed and resulted in an incident in the facility.

An interview with the Behavioural Support Ontario (BSO) Nurse confirmed the staff had applied an inappropriate intervention to the resident. A nursing staff asserted that they were unfamiliar with the resident and unaware of the appropriate intervention to be applied during this situation. The BSO Nurse confirmed the interventions were ineffective. Both the BSO Nurse and the Acting Director of Care stated that the staff required additional training to respond appropriately in the future.

By not implementing strategies and interventions to minimize the risk of altercations and potentially harmful interactions, it resulted in an incident of improper care with the resident.

Sources: Critical Incident Report, a resident's electronic health records, home's internal investigative records, and staff interviews. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (b) identifying and implementing interventions, to be implemented voluntarily.

Issued on this 11th day of March, 2022

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

Original report signed by the inspector.