Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 10, 2017	2017_551526_0003	000710-17	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE MISSISSAUGA
855 JOHN WATT BOULEVARD MISSISSAUGA ON L5W 1G2

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

THERESA MCMILLAN (526), CATHIE ROBITAILLE (536), MELODY GRAY (123)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 12, 13, 14, 16, 17, 18, 19, 20, 23, 24, 25, 26, 27, 28, and 30, 2017.

The following Critical Incident Inspections were completed during this RQI:
005528-15 (Falls prevention)
007948-15 (Falls prevention)
008136-15 (Falls prevention)
024440-15 (Prevention of Abuse)

014014-16 (Falls prevention, Personal Support Services)
017864-16 (Prevention of Abuse)
020590-16 (Falls Prevention, Personal Support Services)
021086-16 (Prevention of Abuse, Reporting and Complaints, Personal Support Services)
023556-16 (Prevention of Abuse, Personal Support Services)
028752-16 (Falls prevention)
001515-17 (Prevention of Abuse, Continence Care and Bowel Management)

The following Complaint Inspections were completed during this RQI:
010080-16 (Pain Management, Personal Support Services)
024417-16 (Duty to protect, Transferring and positioning)
031185-16 (Supplies, Reporting and Complaints, Prevention of Abuse)
032132-16 (Personal Support Services)
001715-17 (Prevention of Abuse, Reporting and Complaints)
002369-16 (Prevention of Abuse, Skin and Wound, Personal Support Services)

Complaint inspection 2017_551526_0004 / 014018-16, 024869-16, 025274-16 was severed from this RQI report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Social Worker, Physiotherapist, Office Manager, Program Manager, Environmental Manager, Maintenance Supervisor, Behaviour Supports Ontario (BSO) staff, Resident Assessment Instrument (RAI) Coordinator, program staff, residents, and family members.

During the course of the inspection, the inspector(s) toured the home, observed residents, reviewed health records, investigative notes, and policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **8 WN(s)**
- **4 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	Legendé 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).

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 the plan of care set out clear directions to staff and others who provide direct care to the resident as evidenced by:

Resident #022's health record was reviewed and indicated different diets and consistencies in the written plan of care, diet and fluid order sheet, and referral notes. The DOC confirmed that the plan of care for resident #022, did not give clear directions regarding diet to staff who provide direct care. [s. 6. (1) (c)]

2. The licensee failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary as evidenced by:

The record of resident #023 indicated their transferring needs in the plan of care for lift and transfer. On a specified day in 2016, resident #023's condition began to deteriorate, and they were assessed by a physician and a treatment prescribed. The health record indicated that their health condition continued to deteriorate. The resident had not been assessed by a nurse in extended class or physician, and had not received the prescribed treatment over a 12 day period. A PSW interview and progress notes indicated that the resident's condition changed, and they had not been assessed. [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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with regarding medication administration.

According to O. Reg. 79/10 s.114(2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. The home's pharmacy service provider's policy The Medication Pass #3-6 dated 01/14 was reviewed and included: "document on MAR in proper space for each medication administered or document by code if medication not given."

The record of resident #022 was reviewed indicated that a medication was given after a family member asked staff not to give it to the resident. The home's investigation revealed that the nurse was interviewed and reported that if the family requested that the medication be held it would have been. The DOC was interviewed and reported that it is the home's expectation that if the medication were not administered the staff would document that using the appropriate code number. There was no physician's order to hold medications if family requested. [s. 8. (1) (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, 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home’s resident-staff communication and response system clearly indicated when activated where the signal was coming from.

The home’s resident-staff communication and response system consisted of call bell stations that triggered the system, a light that turned on a panel above the door of the room where the system was triggered, a sound at the home area nursing station, along with a display panel at the nursing station informing staff where the signal was coming from. The personal support workers (PSWs) also used paging devices (pagers) that vibrated and/or sounded when the system was triggered.

During tour of home areas Long Term Care Homes (LTC) Inspectors observed the following regarding the home's resident-staff communication response system:
1) When activated, call stations triggered display panel and a faint sound at the nursing station that could not be heard throughout the home area or if a PSW was in some resident rooms; PSW staff confirmed this;
2) PSW staff confirmed that they were not always at the nursing station to be alerted by the sound and the display panel about where the system had been activated
3) Paging devices did not alert staff regarding the location of the system activation if the battery was low;
4) PSW staff confirmed that they didn't always carry a paging device if one was not available or broken;
5) PSW staff confirmed that they may take their pager on break leaving a staff person on the unit without a paging device;
6) When activated, call stations in two specified resident rooms did not trigger the system.

The Administrator and DOC described contingencies when pagers were broken, and confirmed that the contingency plan had not been implemented when paging devices were not available and not all staff were carrying a pager. The home's Administrator and Maintenance Supervisor confirmed that there were areas in the home where the resident-staff communication and response system, when activated, did not clearly indicated where the signal was coming from. [s. 17. (1) (g)]

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 ensure that the home is equipped with a resident-staff communication and response system that, in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

On a specified day in 2016, resident #038 was observed to have sustained an unwitnessed injury. Resident #037's health record indicated that they had an altercation with resident #038. The Director of Care (DOC) was interviewed and confirmed information contained in the home's records and the residents' records.The home failed to ensure that resident #038 was protected from abuse by resident #037. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone and that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

The home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy number RC-02-01-01, last updated April 2016, directed that "any person who has reasonable grounds to suspect that any of the following has occurred, or may occur, must immediately report the suspicion and the information upon which it is based to the Director of the Ministry of Health and Long Term Care: 1. Improper or incompetent treatment or care of a Resident that resulted in harm or a risk of harm to the Resident. 2. Abuse of a Resident by anyone or neglect of a Resident by the licensee or staff that resulted in harm or a risk of harm to the Resident."

A) According to health records, resident #006 reported that on a specified day in 2016, a PSW had allegedly abused them causing pain. Review of progress notes indicated that a family member complained about the incident and the home began an investigation the following day. Review of the home's investigative notes indicated that a Critical Incident System (CIS) report was submitted three days after the home became aware of the incident and only after the family submitted a written complaint. The DOC confirmed that the suspected abuse of resident #006 had not been immediately reported to the Director according to the home's policy.

B) Resident #008 complained to the LTC Inspector that on a specified day in 2016, resident #008 complained that they were verbally abused by PSW #122 after they told the PSW that they had a negative outcome after waiting too long after requesting care. This allegation was brought to the attention of the Administrator and DOC. Review of the home's investigative notes and the Critical Incident System (CIS) indicated that the home submitted a report to the Director four days after becoming aware of the allegation of abuse. During interview, the Administrator confirmed that a report was not made to the Director immediately upon becoming aware of an allegation of abuse, according to the home's "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting" policy. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to ensure that mobility devices, including wheelchairs, walkers and canes, were available at all times to residents who required them on a short-term basis as evidenced by:

Review of resident #022's health record indicated their needs and preferences regarding ambulation and seating. They required the use of a temporary wheelchair while a permanent purchase could be made. According to progress notes and interview with the Program Manager, the resident received a permanent wheelchair three weeks later, but had not been provided with a temporary wheelchair in the interim. The home failed to ensure that a wheelchair was available to resident #022 who required it on a short-term basis. [s. 39.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment.

Resident #006's health record indicated that the resident's continence status had worsened over a period of one year. The home's policy "Continence Management Program" policy reference: RESI-10-04-01, created: November 2013, stated: An assessment is completed: upon admission; with any deterioration in continence level, at required jurisdictional frequency if different from above and with any change in condition that may affect bladder and bowel continence. The RAI MDS Coordinator confirmed that a bladder continence assessment should have been completed when the resident #006's bladder continence worsened. [s. 51. (2) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home complied with the manufacturer’s instructions for expiration dates and pharmacy directives.

On January 20, 2017, all medication carts in the home were checked for eye drops and insulins to ensure they were dated as to when they were opened, and when they were to be discarded as per the home’s pharmacy directive. The inspector noted that two opened ophthalmic solutions and four opened insulins that were being provided to residents had not been discarded after 28 days as directed.

The home's clinical pharmacist confirmed that all eye drop labels identify the number of days eye drops can be opened as the dates can vary, and that the directive for insulin's used in the home is 28 days. Registered staff #130 confirmed that insulin’s and eye drops should be disposed of as per pharmacy directive. [s. 129. (1) (a)]

Issued on this 17th day of February, 2017

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

Original report signed by the inspector.