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*

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

Division des foyers de 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
Apr 29, 2019	2019_650565_0006	021343-17, 022155-17, 003336-18, 006543-19	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 Mississauga
855 John Watt Boulevard MISSISSAUGA ON L5W 1G2

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

MATTHEW CHIU (565)

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): March 19, 20, 21, 22, 25, 26, 27, 28, April 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 15, 16, and 17, 2019.

During the course of the inspection, the following Complaint intake logs were inspected:
- 021343-17, 003336-18 related to improper care of resident,
- 022155-17 related to administration of drugs and improper care of resident, and
- 006543-19 related to staff to resident abuse and neglect.

During the course of the inspection, the Complaint Intake log #023596-17 was inspected by inspector #565 during inspection #2019_650565_0008. Finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) related to resident #007, and it is issued together with the non-compliances of this inspection.

During the course of the inspection, the Critical Incident System (CIS) intake log #000125-19 was inspected by inspector #565 during inspection #2019_650565_0007. Finding of non-compliance was identified under LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) (a) related to resident #011, and it is issued together with the non-compliances of this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Office Manager (OM), Food Services Manager (FSM), Physiotherapist (PT), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Residents, and Family Members.

The inspectors conducted observations of resident to resident interactions, staff to resident interactions and provision of care, record review of resident and home records, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

- **2 WN(s)**
- **2 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. 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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

A complaint related to improper continence care for resident #001 was reported to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2018.

Review of resident #001's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment, and the plan of care revealed the resident had cognitive and physical impairments. The plan of care stated resident #001 had a specified continence care routine.

Multiple observations on three identified dates and time periods revealed that resident #001's continence care was performed in an identified manner that not specified in the plan.

Interviews with PSW #103 and RPN #104 indicated that resident #001 was incontinent since they were admitted to the home. Due to the identified changes in resident #001's physical functioning, their toileting plan of care had been changed. The staff members indicated that resident #001 had been given the specified continence care in the above mentioned identified manner. Further, during another specified care activity for resident #001, their continence care should be given to them in the above mentioned identified manner. RPN #104 further stated that the specified continence care given in the above mentioned identified manner was the routine and planned care for resident #001, and it was not specified in their plan.

Interview with the DOC indicated that the planned continence care for resident #001 should have been given in the above mentioned identified manner. The DOC confirmed that resident #001's plan of care did not set out the planned care as mentioned. [s. 6. (1) (a)]

2. Review of a CIS report revealed that resident #011 had a fall on an identified date. As a result, the resident sustained a significant injury and was transferred to the hospital later.

Review of resident #011's RAI-MDS assessment and plan of care revealed that the resident had cognitive and physical impairments. The plan of care further revealed that resident #011 was at risk for falls and had interventions in place for falls prevention. The plan of care had not mentioned a specified falls prevention intervention for the resident.

Multiple observations on two identified dates revealed that the above mentioned specified falls prevention intervention was provided to resident #011 while they were using an identified mobility device.

Interviews with PSW #106, #108, and RPN #109 indicated that resident #011 started using the identified mobility device when they returned from the hospital after the above mentioned injury. The staff further stated the resident was at risk for falls and they might attempt a specified action related to the use of the mobility device. The above mentioned specified falls prevention intervention was implemented for the resident to prevent falls when using the mobility device. Upon reviewing resident #011's plan of care with RPN #109, they confirmed that the plan of care did not set out the use of the above mentioned specified falls prevention intervention.

Interview with the DOC indicated that they were aware of the use of the specified falls prevention intervention for resident #011, and stated it was initiated in an identified month and year. The DOC confirmed that the written plan of care for resident #011 did not set out the use of the above mentioned specified falls prevention intervention as required. [s. 6. (1) (a)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Review of a written complaint forwarded by the home to the MOHLTC revealed that on

an identified date, a family member of resident #001 complained about improper care for the resident. One of the concerns was related to a specified intervention that it was not implemented as required.

Review of resident #001's RAI-MDS assessment and the plan of care revealed that the resident had cognitive and physical impairments. The plan of care further stated the resident was at high risk for an identified health condition and the above mentioned specified intervention should be provided daily to the resident.

On an identified date and time period, multiple observations indicated that resident #001 had developed the identified health condition, and the above mentioned specified intervention was not provided to them as required.

Interview with PSW #103 on the same day after the above observations indicated that the specified intervention should have been provided to the resident #001 at all times for their identified health condition. PSW #103 confirmed that they noticed the specified intervention was not provided to the resident on their shift and they corrected it afterwards.

Interview with RPN #104, who worked during the above mentioned observations, stated that the specified intervention was started for resident #001's identified health condition a few months ago. RPN #104 did not recall if the specified intervention was provided to the resident on the above mentioned date as required.

Interview with the DOC indicated that resident #001's plan of care directed staff to apply the specified intervention for the resident's identified health condition. The DOC acknowledged that the specified intervention was not provided to resident #001 as specified in the plan, as mentioned above. [s. 6. (7)]

4. A complaint related to improper care for resident #007 was reported to the MOHLTC on an identified date in 2017. The complainant stated that the resident was supposed to have a specified type of therapy. On an identified date, the complainant found that resident #007 was not receiving the therapy.

Review of resident #007's RAI-MDS assessment revealed the resident had cognitive and physical impairments. The identified assessments and progress notes revealed the resident had identified health and medical conditions.

Review of resident #007's physician orders, which were a part of the resident's plan of care, revealed that the specified therapy was initiated on an identified date and time for an identified number of days continuously. It was revised on a subsequent date and time with a supplementary note stating the specified reason.

Review of resident #007's progress notes indicated that on an identified date and time, a family member found resident #007 not receiving the specified therapy and reported it to RPN #115. It was confirmed by a PSW and RPN #115. RPN #115 took subsequent specified actions related to the above mentioned specified reason and restarted the specified therapy.

Interview with RPN #117 indicated that resident #007 was at risk for an identified health condition and had received the specified therapy in 2017. RPN #117 did not recall any incident related to resident #007' specified therapy.

Interview with RPN #115 indicated that they did their first round on resident #007's home area on the identified date and time, and they did not check if the specified therapy was given to the resident or not. Later, resident #007's family reported to RPN #115 at an identified time that the specified therapy was not given to the resident. Subsequently, RPN #115 was told by a PSW that they noticed the specified therapy was not given to resident #007 from the time they started their shift. RPN #115 took subsequent specified action and reapplied the specified therapy to the resident. RPN #115 further stated resident #007's specified therapy should be applied continuously until an identified date.

Interview with the DOC indicated the above mentioned order for the specified therapy was part of resident #007's plan of care, and confirmed that it was not given to resident #007 as specified in the resident's plan as mentioned above. [s. 6. (7)]

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:
- there is a written plan of care for each resident that sets out the planned care for the resident, and
- the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint related to an identified drug administration and improper care for resident #003 was reported to the MOHLTC on an identified date in 2017.

Review of the identified drug orders for resident #003 revealed specified changes in the directions for administration during an identified time period.

Review of the electronic medication administration records (eMAR) for resident #003 revealed that the last identified drug order during the above mentioned identified period was discontinued on an identified date and reinstated six days later. The resident did not receive the identified drug during identified dates.

Interview with RPN #105 revealed that they recalled there was a medication incident related to the identified drug administration for resident #003. The identified drug dosage was changed, and the resident missed the identified drug for a period of time as required.

Review of the home's investigation records indicated on an identified date, the doctor made a specified change to the dosage of the identified drug for resident #001. Due to a specified event, the identified drug was discontinued for the resident on an identified date by mistake.

Interview with the DOC indicated when the family member visited the resident on the identified date, they discovered the resident had not received the required identified drug and reported it to the registered staff. The home immediately investigated and reinstated the order on the identified date. The DOC confirmed that the identified drug was not administered to resident #003 during the above mentioned identified dates as required. [s. 131. (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 that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 2nd day of May, 2019

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

Original report signed by the inspector.