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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 25, 2014	2014_210169_0007	H-000299-14	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

YVONNE WALTON (169), CYNTHIA DITOMASSO (528), KATHLEEN MILLAR (527), VALERIE GOLDRUP (539), VIKTORIA SHIHAB (584)

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): March 18, 19, 20, 21, 24, 25, 26, 27, 28, 2014

A complaint inspection H-000283-14 was completed with this Resident Quality Inspection. See separate report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Office Manager, Social Worker, Program Manager, Staff Education Coordinator, Environmental Manager, Maintenance Supervisor, Food Service Manager, Registered Dietitian, RAI MDS Coordinator, Physiotherapist, Registered Nursing staff, Personal Support Workers, families and residents.

During the course of the inspection, the inspector(s) observed all home areas, reviewed policies and procedures, minutes of meetings and reviewed clinical records.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that where bed rails were used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

Resident #548 was observed in bed with both full bed rails in the upright position on March 19, 20, 21, 24 and 25, 2014. Documentation in the clinical record indicated there was no risk assessment and no evaluation completed to minimize the risk to the resident. There was no clinical documentation to support that an assessment was conducted to prevent resident entrapment. The Administrator and the Director of Care confirmed no bed entrapment assessment was performed on the resident's bed.

Resident #608 was observed in bed with two quarter rails in the upright position. A review of the clinical documentation confirmed there was no assessment of the bed system for bed entrapment, and/or an evaluation of the entrapment zones. The Administrator and the Director of Care confirmed that no bed entrapment assessment was performed on the resident's bed system.

Resident #624 was observed in bed with two assist rails in the up position. In reviewing the clinical documentation there was no assessment of the bed system for bed entrapment, and/or an evaluation of the entrapment zones. The Administrator and the Director of Care confirmed that no bed entrapment assessment was performed on the resident's bed system.

The Administrator and the Director of Care confirmed the last Bed Entrapment assessment was conducted in 2011. Resident #608 and 624 were not residents in the home at the time of the bed entrapment audit, and Resident #548 was using a different type of bed at the time of the home's assessment.

The Administrator confirmed that after they replaced 140 of their mattresses in 2013, a bed entrapment assessment was not conducted. [s. 15. (1) (a)]

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. 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 did not ensure the plan of care set out clear directions to staff and others who provide direct care.

The current plan of care for Resident #624 directed staff to clean the resident's teeth after meals and at bedtime, or rather four times a day. The kardex used by the personal support workers provided no direction to the staff regarding oral care. The flow sheets identified Resident #624 received oral care twice a day. Staff confirmed they provide oral care to the resident twice per day. [s. 6. (1) (c)]

2. The current plan of care for Resident #529 directed staff to toilet the resident after meals. In another part of the plan of care it directed staff to toilet the resident upon waking, bed time, and every three hours. On March 21, 2014, direct care staff stated that the resident called them to use the bathroom and was not on a scheduled toileting

routine. On March 24, 2014 another direct care staff member stated the resident is toileted before and after meals. The plan of care did not provided clear directions for the staff. [s. 6. (1) (c)]

3. The current plan of care for Resident #608 directed staff to provide one person assist for toileting. In another part of the plan of care it directed staff to assist and supervise the resident during toileting. The kardex directed staff to have two staff at all times for toileting. Interview with staff confirmed the plan of care did not provide clear directions to them regarding toileting. [s. 6. (1) (c)]

4. The current plan of care for Resident #524 directed staff to provide limited assistance with bed mobility. In another part of the plan of care it directed staff to have two staff provide assistance. On March 27, 2014, two direct care staff confirmed that the resident was totally dependent and required two staff for assistance with bed mobility. The Resident Assessment Instrument (RAI) coordinator confirmed that the plan of care did not provide clear directions to staff. [s. 6. (1) (c)]

5. The licensee failed to ensure that clear directions regarding residents' special diets, special needs and preferences are provided to food service workers and other staff assisting residents.

The current nutritional plan of care for Resident #402 indicated the resident was not meeting their hydration needs. The resident's fluid goal indicated the resident was to receive 2000 millilitres (ml)/day. The resident's current diet list indicated that the resident was to receive a different amount. Interviews with three Personal Support Workers and two Dietary Aides on March 19, 21 and 23 confirmed the staff used the servery diet sheet to provide nutrition and hydration care to residents. A review of the Registered Dietitian referrals for the resident revealed the Nurse Practitioner sent a referral to the Registered Dietitian to clarify the resident's fluid needs in 2013. Fluid goals were not clarified to front line staff, evidenced by lack of updating the diet list. The resident's hydration plan of care did not provide clear direction to staff. [s. 6. (1) (c)]

6. The licensee did not ensure that all residents are reassessed and the plan of care reviewed and revised when the residents care needs change.

The current plan of care for Resident #608 directed staff that the resident was in isolation for an infection. Observation of the resident's room confirmed the resident

was not in isolation and there was no personal protective equipment available to staff. The plan of care identified the resident required this in 2013 and the plan of care was not updated.

The current plan of care for Resident #608 directed staff to provide antibiotics for ten days in 2013. The medication record indicated the resident finished the antibiotics in 2014. The Personal Support Workers confirmed the resident was not in isolation and the Registered Practical Nurse confirmed the antibiotics were completed February 4, 2014. The plan of care was not updated to reflect the current care needs of the resident.

The current plan of care for Resident #603 directed the staff to provide antibiotics in February 2014. The resident finished the antibiotics March 2, 2014 and the plan of care was not updated to reflect the treatment was no longer necessary. The Registered Practical Nurse confirmed the antibiotics were completed and the plan of care was not updated.

The current plan of care for Resident #548 directed staff to provide care for a stage two treatment, however the resident had a stage 3 treatment. The documentation confirmed the resident had a stage 3 treatment and the plan of care was not updated.

The current plan of care for Resident #548 provided no direction to staff regarding the use of bed rails. The resident was in bed at all times during the inspection. Observation of the resident revealed the resident had two full bed rails up in bed. Staff confirmed they use two bed rails for this resident.

The current plan of care for Resident #548 directed staff to porter the resident to activity programs and indicated the resident walks with total assistance by two staff members. The resident no longer walked or attended programs as they have been in bed at all times.

The current plan of care for Resident #548 directed staff to use one staff person to mobilize and reposition the resident in bed. In another section of the written plan of care it directed staff to use one or two staff to assist the resident in bed. The plan of care also stated the Resident is transferred into a chair by two staff using the hoyer lift and will be transferred back to bed after two to three hours. The resident was identified as being on bed rest. The registered staff and PSW's stated the resident

was cared for in bed at all times and did not get out of bed anymore. The clinical documentation supports the resident has been cared for in bed, has not been up in a chair, and has not been participating in activities. [s. 6. (10) (b)]

7. The current plan of care for Resident #612 directed staff to use a bed alarm for the resident when they were in bed. Observation of the resident's room confirmed the resident did not have a bed alarm on the bed. A Personal Support Worker stated the resident did not use a bed alarm. The Registered Practical Nurse confirmed the plan of care had not been reviewed to update the resident's current status.

The current plan of care for Resident #612 identified the resident had a problem related to an injury which occurred in 2011. The current plan of care was not updated to reflect the current status of the resident. The Assistant Director of Care confirmed the current plan of care had not been updated.

The current plan of care for Resident #592 directed staff to use a fall mat in their room on the floor while in bed. Observation of the resident's room confirmed the resident did not have a fall mat beside their bed. The RPN and the PSW stated the resident did not need to use a fall mat. [s. 6. (10) (b)]

8. The plan of care for Resident #608 was revised in February, 2014 by the Registered Dietitian. The resident's hydration goals were calculated based on a specific weight. The clinical record identified the resident's weight was different. The resident's hydration goals were calculated based on a weight which was fifteen months old and was not calculated based on the current weight.
The plan of care was not updated to reflect their increased hydration needs. [s. 6. (10) (b)]

9. The plan of care for Resident #540 was revised on January 9, 2014 by the Dietary Manager. The resident's nutrition and hydration goals were calculated based on a specific weight. At the time of the review, the resident's weight was different. The resident's nutrition and hydration goals were calculated based on a weight which was six months old. The plan of care was not updated to reflect their changing needs. [s. 6. (10) (b)]

10. The plan of care for Resident #674 was revised on February 4, 2014 by the Dietary Manager. The resident's nutrition and hydration goals were calculated based on a specific weight. At the time of the review, the resident's weight was different.

The resident's nutrition and hydration goals were calculated based on a weight which was eleven months old. The plan of care was not updated to reflect their increased nutrition and hydration needs. [s. 6. (10) (b)]

Additional Required Actions:

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

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 of a long-term care home did not ensure the Narcotic Drug policy was followed.
The Narcotic medication destruction process was reviewed with the Assistant Director of Care (ADOC). The ADOC was unable to provide a copy of the Log Record of Narcotics for Destruction for the discontinued Narcotics that were in the locked Narcotic Destruction box. The policy was reviewed with the ADOC who confirmed the form had not been completed. [s. 8. (1)]

2. The licensee did not ensure the policy named "Communication Systems", #RESI-08 -02-01, was complied with.

The policy directs staff to ensure the call bell is easily accessible to the resident at all times. The policy stated the call bell at the bedside should be easily accessible to the resident at all times. The policy indicated the call bells should be in reach and not be secured to bed rails or movable objects. Two residents, #592 and #694 were observed with their call bells outside of their reach while they were lying in bed.

Resident #592 had their call bell clipped to itself against the wall. Resident #624 had a call bell that was difficult to activate due to a sticky button.
Observation of Resident #607, #540 and #524 revealed their call bells were tied to the safety bar in their ensuite washroom. All three ensuite call bells could not be activated by pulling on the string. The nursing staff could not explain why the call bells were inaccessible.

The policy stated the staff should document their checks of the call system on each resident's daily care record. A review of the seven residents care record indicated there was no documentation of checks of the call system. The Director of Care confirmed there is space to document the call bell on the new Daily Record of Care implemented in the Fall of 2013, however it was not completed. [s. 8. (1)]

3. The licensee did not ensure the policy named "Food and Fluid Intake Monitoring", # RESI-05-02-05, version November 2013, was complied with.

a) The policy directs registered staff to conduct a dehydration assessment if a resident's fluid intake falls below the fluid goals calculated by the dietitian for three consecutive days and the results of the dehydration assessment must be documented. The policy also states that, if signs and symptoms of dehydration are noted during the assessment, immediate interventions to improve fluid intake must be implemented and a referral to the dietitian must be made.

The Resident Daily Food and Fluid Intake record for Resident #608 was reviewed on March 19, 2014. The resident's daily fluid intake for March 4 - 7, 2014 and March 15 - 19, 2014 was documented to be 6-7 servings per day. The resident's plan of care indicated their fluid goals are 9 servings per day. The resident consumed 2-3 servings of fluid below their fluid goals for four consecutive days and again for five consecutive days. As per policy, Registered Staff members were expected to conduct a dehydration assessment after three consecutive days of fluid intake below their fluid goals, and to document the results of the dehydration assessment. Based on the results of the assessment, the Registered Staff were expected to complete a low fluid intake referral to the Registered Dietitian if signs and symptoms of dehydration were noted.

A review of the Registered Dietitian referrals confirmed that no low fluid referral for the resident was received by the dietitian by March 26, 2014. The Registered Dietitian confirmed on March 21, 2014 that she was not aware of the resident's low fluid intake

because she did not receive a referral from registered staff. A follow up conversation with the Registered Dietitian on April 1, 2014 confirmed that the dehydration assessment would be documented by registered staff in the Progress Notes, if one had been conducted. A review of the resident's progress notes confirmed that no dehydration assessment was completed. On April 1, 2014, the dietitian confirmed the dehydration assessment was not conducted. The resident had a fluid intake below their calculated goals for nine days and Registered Staff failed to conduct a dehydration assessment or refer the low intake to the dietitian as per policy.

The Resident Daily Food and Fluid Intake record for Resident #400 was reviewed on March 19, 2014. The resident's daily fluid intake from March 11 to March 19, 2014 was documented to be 4.5-9 servings per day. The resident's plan of care indicated their fluid goals are a minimum of 10 servings per day. The Registered Dietitian confirmed on March 25, 2014 that she was unaware of the resident's nine days of low fluid intake. A review of the Registered Dietitian referral records confirmed that no low fluid referral was received by the Registered Dietitian by March 26, 2014. All staff progress notes for the resident for March 1 to March 25, 2014 were reviewed. A dehydration assessment was not completed. On April 1, 2014, the Registered Dietitian confirmed the dehydration assessment was not conducted.

c) The Resident Daily Food and Fluid Intake record for Resident #401 was reviewed on March 19, 2014. The resident's daily fluid intake from March 9 - March 12, 2014 and March 17 - March 19, 2014 was documented to be 10-11.5 servings per day. The resident's plan of care indicated that their fluid goals are a minimum of 12 servings per day. The Registered Dietitian confirmed on March 25, 2014 that she was unaware of the resident's seven days of low fluid intake. A review of the Registered Dietitian referral records confirmed that no low fluid referral was received by the dietitian by March 26, 2014. On April 1, 2014, the dietitian confirmed the dehydration assessment was not conducted.

The policy "Food and Fluid Intake Monitoring", # RESI-05-02-05, version November 2013, also states that a referral to the Registered Dietitian must be sent if the resident leaves 25% or more of foods for 2 out of 3 meals over a seven day period.
The Resident Daily Food and Fluid Intake record for Resident #403 was reviewed on March 19, 2014. The resident's daily food intake for March 1 to March 19 was documented with the resident leaving 25% or more of the meal uneaten, for 2-3 meals out of the three daily meals. The resident had a low food intake for nineteen consecutive days. As per policy, registered staff members were expected to complete

a low food intake referral to the Registered Dietitian if a resident left 25% at two out of the three meals for seven consecutive days. On March 25, 2014 the Registered Dietitian confirmed that no nutrition referrals were made regarding the resident's low food intake on March 1 to March 19, 2014. A review of the dietitian's referrals confirmed the dietitian had received no referrals related to the resident from February 18 to March 26, 2014. An interview with the resident's family confirmed the resident had not eaten well for the past year. The registered staff failed to adhere to the home's policy by completing a referral to the dietitian after the resident had 19 days of poor food intake. [s. 8. (1) (a),s. 8. (1) (b)]

4. The licensee did not ensure that the policy and procedure named "Personal Assistance Service Devices, RESI-10-01-06" was complied with.

The home's policy directs staff to use a Personal Assistance Safety Device (PASD) only after all other alternative means of assisting the resident with an activity of daily living has been trialled and the resident's care plan states the purpose and time frame for the use of the PASD. Observation of Resident #548, 608 and 624 showed they were using bed rails as a PASD and there was no documentation of alternatives being trialled and there was no documentation in the plan of care regarding a PASD. Staff confirmed that no trial of alternatives had been completed and there was no documentation on the plan of care.

The home's policy directs staff to obtain approval for a PASD and must specify the type of PASD to be used, when it should be used and how long, and the approval must be documented in the resident's clinical record. Observation of Resident #548, 608 and 624 showed they had a PASD in use and there was no documentation of approval for the PASD, when it should be used and for how long in the clinical records. This was confirmed by staff.

The home's policy directs staff to obtain informed consent for the use of the PASD from the resident or the Power of Attorney (POA) or Substitute Decision Maker (SDM) and all the risks and benefits associated with PASD use has been explained, the alternatives that were attempted and evaluated were explained and the resident or POA or SDM have been given the opportunity to have any questions answered. Observation of Resident #548, 608 and 624 showed they had a PASD in use. There was no documentation of a signed consent for a PASD, and the informing process to the resident or POA or SDM, in the residents' clinical record. This was confirmed by staff.

The home's policy directs staff to complete on a quarterly basis, the ongoing benefit of PASD use for residents at the quarterly care review and changes will be made on the plan of care. Resident #548, #608 and #624 had no review of the PASD in the quarterly care review and there was no documentation in the plan of care. The nursing staff confirmed the quarterly review was not completed.

The home's policy directs staff to annually evaluate PASD use as part of the Minimizing of Restraints Quality Protocol. There was no documentation in the home's Annual Quality Program Evaluation completed May 2013. The Director of Care confirmed the lack of evaluation.

Several staff interviewed, including registered staff did not know what a PASD was or what the requirements of the home's policy included, even though training had been provided. [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 that ensures the licensee of a long-term care home have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (1) This section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD. 2007, c. 8, s. 33. (1).

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee did not ensure the following were satisfied prior to including in the resident's plan of care: that alternatives to the use of a PASD had been considered, and tried where appropriate, but would not be, or have not been, effective to assist the

resident with the routine activity of daily living.
s. 33(4) (1)

Resident #548 was observed in bed with both full bed rails up on March 19, 20, 21, 24 and 25, 2014. They were being used a PASDs. The resident's condition had deteriorated, however, the plan of care was not revised. There was no documentation in the clinical record that alternatives had been considered. This was confirmed by staff.

Resident #608 was observed up in a wheelchair on March 19, 20, 24 and 25, 2014. The Resident had two quarter rails up on her bed and the plan of care directed staff to use them when the resident was in bed, as a PASD. There was no documentation in the clinical record that alternatives had been considered. This was confirmed in an interview by staff.

Resident #624 was observed up in their specialty wheelchair March 19, 20, 24 and 25, 2014. The Resident had two assist bed rails up and the plan of care directed staff to use them when the resident was in bed, as a PASD. There was no documentation in the clinical record that alternatives to had been considered. This was confirmed by staff. [s. 33. (1)]

2. The licensee did not ensure the Personal Assistance Service Device (PASD) described in subsection (1) was used to assist residents with routine activities of daily living only if the use of the PASD is included in the resident's plan of care.

Resident #548 was observed in bed with full bed rails up on March 19, 20, 21, 24 and 25, 2014. The Resident Assessment Instrument Minimum Data Set (RAI-MDS) completed on December 12, 2013 identified that bed rails are used for positioning and safety. The bed rails had not been identified as a PASD on the written plan of care. This was confirmed by staff.

The Resident Assessment Instrument Minimum Data Set (RAI-MDS) for Resident #608 completed on January 24, 2014 identified that two quarter bed rails are used by the resident for turning in bed and transferring in and out of bed. They had not been identified as a PASD on the written plan of care. This was confirmed by staff.

The Resident Assessment Instrument Minimum Data Set (RAI-MDS) completed on March 21, 2014 for Resident #624 identified that two assist bed rails are used for

repositioning and transferring in and out of bed. They had not been identified as a PASD on the written plan of care. This was confirmed by staff. [s. 33. (3)]

3. The licensee did not ensure the use of a Personal Assistance Services Device (PASD) to assist a resident with a routine activity of living was included in the plan of care for Resident #548, 608 and 624 and included alternatives, the use is reasonable, it was approved by a professional outlined in s. 33 (4)(3), and the PASD was consented to by the resident or Power of Attorney.

Resident #548 was observed having two full bed rails up while in bed. The staff identified they are used for positioning, for healing of pressure ulcer, and safety. There was no documentation of the PASD on the written plan of care. Personal Support Workers (PSWs) and Registered Staff confirmed the resident was using a PASD.

Resident #608 was observed using two quarter rails while in bed. The staff identified they used the two rails to assist the resident with positioning. There was no consent in the clinical record for the use of the PASD. Staff confirmed there was no consent obtained.

Resident #624 was observed with assist bed rails in the upright position while in bed, on March 20 and 21, 2014. Staff stated both rails are used by the resident for positioning and transferring. The plan of care did not identify the bed rails were being used a PASD. There is no approval for a PASD, assessment, evaluation, or consent on the resident's clinical record.

4) Four PSW's and two Registered Staff were interviewed and stated that none of the residents had a restraint. Only one of the registered staff members knew what was a PASD. The other staff where not aware.

The licensee did not ensure Resident #548, 608 and 624 had approval, assessment, evaluation and consent for a PASD. [s. 33. (4)]

4. There is no documentation that the use of the PASD had been approved by a physician, a registered nurse, a registered practical nurse, a member of the College of Occupation Therapists of Ontario, a member of the College of Physiotherapists of Ontario, or any other person provided for in the regulation, for Resident #548, 608 and 624.

Resident #548, #608 and #624 did not have PASD approval documented in the clinical record. This was confirmed by staff. [s. 33. (4) 3.]

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 ensures the personal assistance service devices described in subsection (1) are used to assist residents with routine activities of daily living only if the use of the PASD is included in the resident's plan of care, included in the plan of care, includes alternatives, approval by a professional and consented to by the resident or Power of Attorney, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that food service workers and other staff assisting resident's are aware of the resident's diets, special needs and preferences.

The Physician's Orders for Resident #401 were reviewed. Three Personal Support Worker staff and two Dietary Aides were interviewed at different meal times on March 19, 21 and 26, 2014. The staff indicated they followed the Diet List when providing nutrition and hydration care to residents. The staff were not aware of the resident's diet order change because it was not updated on the resident's Diet List when the list was revised.

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 ensures that the home has a dining and snack service that includes, at a minimum, a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 245. Non-allowable resident charges

The following charges are prohibited for the purposes of paragraph 4 of subsection 91 (1) of the Act:

1. Charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from,

i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under a service accountability agreement, and

ii. the Minister under section 90 of the Act. O. Reg. 79/10, s. 245.

2. Charges for goods and services paid for by the Government of Canada, the Government of Ontario, including a local health integration network, or a municipal government in Ontario. O. Reg. 79/10, s. 245.

3. Charges for goods and services that the licensee is required to provide to residents under any agreement between the licensee and the Ministry or between the licensee and a local health integration network. O. Reg. 79/10, s. 245.

4. Charges for goods and services provided without the resident's consent. O. Reg. 79/10, s. 245.

5. Charges, other than the accommodation charge that every resident is required to pay under subsections 91 (1) and (3) of the Act, to hold a bed for a resident during an absence contemplated under section 138 or during the period permitted for a resident to move into a long-term care home once the placement co-ordinator has authorized admission to the home. O. Reg. 79/10, s. 245.

6. Charges for accommodation under paragraph 1 or 2 of subsection 91 (1) of the Act for residents in the short-stay convalescent care program. O. Reg. 79/10, s. 245.

7. Transaction fees for deposits to and withdrawals from a trust account required by section 241, or for anything else related to a trust account. O. Reg. 79/10, s. 245.

8. Charges for anything the licensee shall ensure is provided to a resident under this Regulation, unless a charge is expressly permitted. O. Reg. 79/10, s. 245.

Findings/Faits saillants :

1. The licensee did not ensure the charges for goods and services that a licensee is required to provide to a resident funded by the Minister under section 90 of the Act, were prohibited. O. Reg s. 245 (1).

In June, 2013, the wound care nurse ordered wound care supplies for Resident #548 and requested approval of payment from the Power of Attorney (POA). Review of pharmacy invoices from June 2013 to March 2014, revealed money was paid by the POA for wound care supplies. Interview with the wound care nurse confirmed that the POA for Resident #548 was charged for wound care supplies funded by the MOHLTC under the nursing and personal care funding envelope.

2. Resident #201, #202, #205, #206, #208, #210 and #211 received continence assessments, which indicated that each resident were to wear a pull up type of incontinence products. As part of the range of incontinence products provided by the home, pull up types are provided. They are identical to the ones provided by the families. A review of the home's "incontinence product list" outlined the above residents supplied their own pull ups incontinence products. Discussions held with families on March 25 and 26, 2014, confirmed they were supplying the residents with pull up type of incontinent products and paying for them out of pocket. Interview with registered and direct care staff on March 26, 2014 confirmed they were using the incontinent products supplied by the families. Incontinence products are funded by the MOHLTC under Nursing and Personal Support Services, and therefore are required to be provided by the licensee. [s. 245. 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 that ensures charges for goods and services that a licensee is required to provide to a resident using funding that the licensee receives from, i. a local health integration network under section 19 of the Local Health System Integration Act, 2006, including goods and services funded by a local health integration network under service accountability agreement, and ii the Minister under section 90 of the Act. O.Reg. 79/10, s. 245., to be implemented voluntarily.

Issued on this 25th day of April, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs
[redacted] Worker - Lead

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	YVONNE WALTON (169), CYNTHIA DITOMASSO (528), KATHLEEN MILLAR (527), VALERIE GOLDRUP (539), VIKTORIA SHIHAB (584)
Inspection No. / No de l'inspection :	2014_210169_0007
Log No. / Registre no:	H-000299-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Apr 25, 2014
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE MISSISSAUGA 855 JOHN WATT BOULEVARD, MISSISSAUGA, ON, L5W-1G2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	REJANE JONES

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan that ensures where bed rails are used, (a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and (c) other safety issues related to the use of bed rails are addressed, including height and latch reliability.

The plan is to be submitted by May 2, 2014 to Long Term Care Homes Inspector: Yvonne Walton at: yvonne.walton@ontario.ca.

Grounds / Motifs :

1. Resident #548 was observed in a specialty bed with both full bed rails up on March 19, 20, 21, 24 and 25, 2014. There was no risk assessment related to the bed system, and no evaluation was noted in the clinical documentation. There was no clinical documentation to support that an assessment was conducted to prevent resident entrapment. The Administrator and the Director of Care confirmed that no bed entrapment assessment was performed on the resident's specialty bed.

2. Resident #608 was observed in bed with two quarter bed rails in the upright position. In reviewing the clinical documentation there was no assessment of the bed system for bed entrapment, and/or an evaluation of the entrapment zones. The Administrator and the Director of Care confirmed that no bed entrapment assessment was performed on the resident's bed system.

3) Resident #624 was observed up in bed with two assist rails in the up position. In reviewing the clinical documentation there was no assessment of the bed system for bed entrapment, and/or an evaluation of the entrapment zones. The Administrator and the Director of Care confirmed that no bed entrapment assessment was performed on the resident's bed system.

4) The Administrator and the Director of Care confirmed the last Bed Entrapment assessment was conducted in 2011. Resident #608 and 624 were not residents in the home at the time of the bed entrapment audit, and Resident #548 was on a different type of bed at the time of the home's assessment.

5) The Administrator confirmed that after the home replaced 140 of their mattresses in 2013, a bed entrapment assessment was not conducted.

(527)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 23, 2014

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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. 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 prepare and submit and implement a plan that ensures there is a written plan of care for all residents including Resident #529, #608, #524 and #624 that sets out, (c) clear directions to staff and others who provide direct care to the residents.

The plan is to be submitted by April 16, 2014 to Long Term Care Homes Inspector: Yvonne Walton at: yvonne.walton@ontario.ca

Grounds / Motifs :

1. The current nutritional plan of care for Resident #402 indicated the resident was not meeting their hydration needs. The resident's fluid goal indicated the resident was to receive a specific amount per day. The resident's current diet list indicated the resident required a different amount. Interviews with three Personal Support Workers and two Dietary Aides on March 19, 21 and 23, 2014 confirmed the staff used the servery diet sheet to provide nutrition and hydration care to residents. A review of the Registered Dietitian referrals for the resident revealed the Registered Nurse Practitioner referred to the Registered Dietitian to clarify the resident's fluid needs. Fluid goals were not clarified to front line staff, evidenced by lack of updating the diet list. The resident's hydration plan of care did not provide clear direction to staff. The licensee failed to ensure there was a written plan of care that sets out clear directions to staff and others who provide direct care to the resident. (584)

2. The current plan of care for Resident #524 directed staff to provide limited

assistance with bed mobility. In another part of the plan of care it directed staff to have two staff to provide assistance. On March 27, 2014 two direct care staff confirmed that the resident was totally dependent and required two staff for assistance with bed mobility. The resident assessment instrument (RAI) coordinator confirmed it did not provide clear directions to staff. (528)

3. The current plan of care for Resident #608 directed staff to provide one person assist for toileting. In another part of the plan of care it directed staff to assist and supervise the resident during toileting. Interview with staff confirmed the plan of care did not provide clear directions to them regarding toileting. (528)

4. The current plan of care for Resident #529 directed staff to toilet the resident after meals. In another part of the plan of care it directed staff to toilet the resident upon waking, bedtime, and every three hours. On March 21, 2014 direct care staff stated that the resident called them to use the bathroom and was not on a scheduled toileting routine. On March 24, 2014 another direct care staff member stated the resident is toileted before and after meals. The plan of care did not provided clear direction to staff and others who provide direct care. (528)

5. The current plan of care for Resident #624 directed staff to clean the resident's teeth after meals and at bedtime, or rather four times a day. The kardex used by the personal support workers provided no direction to the staff regarding oral care. The flow sheets identified Resident #624 received oral care twice a day. The staff confirmed they provide oral care twice per day. (169)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 30, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 25th day of April, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : YVONNE WALTON

Service Area Office /
Bureau régional de services : Hamilton Service Area Office