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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 15, 2016	2015_251512_0016	T-483-14	Complaint

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 SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

TILDA HUI (512)

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): September 9, 10, 14, and 15, 2015.

Inspection related to the following Log# was completed during this inspection:
T-483-14

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), physiotherapists (PTs), registered nurses (RNs), personal support worker (PSW), family member and substitute decision maker.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

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

Review of resident #001's progress notes revealed the resident was admitted on an identified date into an identified unit. Review of a pain assessment conducted on admission described the resident was complaining of moderate pain localized at an identified site on his/her body, with worsened pain upon movement. Pain was rated by the resident as moderately severe. Action taken by nursing staff at the time was to administer an identified analgesic as needed which was effective in lowering the pain scale to moderate.

Review of the resident's written plan of care did not reveal any indication of interdisciplinary strategies set up to address the resident's issue of pain even though the resident was identified on admission as having pain in the identified site on his/her body. Furthermore, the resident was complaining of mild to severe pain in a second site on his/her body after an incident on an identified date. Review of the written plan of care did not reveal any indication of interdisciplinary strategies developed to address the resident's complaint of pain on the second site on his/her body.

Interview of RN staff #001, staff #002, and the administrator confirmed that there were no

intervention set up in the resident's written plan of care to address the issue of pain. [s. 6. (1) (a)]

2. 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.

Review of resident #001's progress notes revealed the resident had two falls since admission. The first fall occurred on an identified time and date after the resident rang the call bell to be toileted. PSW #005 transferred the resident onto the toilet and left the room. Record review and staff interview indicated the resident got up from the toilet without using the call bell and fell. The PSW and RN #002 heard the resident calling for help and went into the washroom and found the resident on the floor. The resident was assessed and helped into bed, no obvious injury was documented. Pain medication was administered to the resident with effect and the resident was monitored throughout the shift. The resident was transferred to the hospital in the next shift as ordered by the attending physician for further assessment. The resident returned to the home on the same day with no acute injury identified. A test conducted 12 days later indicated possibility of an injury.

Record review indicated the resident had the second fall on an identified date and time. The resident was found on the washroom floor while attempting to transfer him/herself from the wheelchair onto the toilet. The resident admitted having slipped from the wheelchair. No injury was noted post fall. The resident denied any pain and was able to get up with staff's assistance.

Further review of the resident's written plan of care on admission, indicated the physiotherapist (PT) assessed the resident as requiring two person assistance when transferring. Review of the resident's written plan of care also indicated nursing assessed the resident 16 days later as requiring one person's assistance when transferring. However, the record review did not reveal any indication that the PT had changed the assessment during the 16 days.

Interviews with RN staff #001 & #002 indicated they were aware the resident required one person assistance for transfers. They were not aware the resident was assessed as a two person transfer by physiotherapy on admission. Interviews with the PT staff #008 and RN staff #001 revealed the normal process to determine the resident's level of transfer assistance was for the PT to conduct an assessment of the resident on admission. Then the result of the assessment is communicated to nursing and a logo

placed in the resident's room inside a cupboard. The nursing staff then document the level of assistance required in the written plan of care. Any change in the level of assistance is documented in the same process. The PT staff #008 and RN staff #001 confirmed for resident #001, the admission PT assessment was not reflected in the nursing written plan of care.

Interview with the administrator confirmed the resident's written plan of care did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

3. The licensee has failed to ensure that when the resident is reassessed and the plan of care revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care.

Review of the resident's progress notes revealed the resident suffered two fall incidents since admission. The first fall occurred on an identified date and time after the resident rang the call bell to be toileted. PSW #005 transferred the resident onto the toilet and left the room. Record review and staff interview indicated the resident got up from the toilet without using the call bell and fell on the floor. The resident was assessed and helped into bed, no obvious injury was documented. The resident was transferred to hospital in the next shift as ordered by the attending physician for further assessment. The resident returned to the home on the same day.

Record review indicated the resident had the second fall on the second identified date and time. The resident was found on the washroom floor while attempting to transfer him/herself from the wheelchair onto the toilet. The resident admitted having slipped from the wheelchair. No injury was noted post fall.

Review of the resident's plan of care dated two days after admission revealed fall prevention strategies developed included: check every shift for safety during periods where risk for falls is increased, coordinate with appropriate staff to ensure a safe environment i.e. floor surfaces even, fall mat at bedside, glare free lighting, bed in low position, personal items and call bell within reach. Further review of the plan of care revealed the care plan was not revised after the two fall incidents to include new and effective strategies for fall prevention. Record review did not indicate any new fall prevention strategies since the plan of care was developed on admission.

Interviews with RN staff #001 and #002 confirmed that there were no new and effective

fall prevention strategies developed and implemented for the resident after the two above mentioned fall incidents. Interview with the administrator confirmed staff are expected to consider different approaches in the revision of the plan of care if care implemented have not been effective. [s. 6. (11) (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 there is a written plan of care for each resident that sets out the planned care for the resident, that the plan of care set out clear directions to staff and others who provide direct care to the resident, and that when the resident is reassessed and the plan of care revised because care set out in the plan has not been effective, different approaches are considered in the revision of the plan of care, 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 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.

Review of the home's medication policy titled Narcotics & Controlled Drugs, policy number 11-20, revised date December 2011, in the Policy section stated two staff (one leaving and one coming on duty) must complete a narcotic count at the end/beginning of each shift. In the Procedure section item #9 stated the count will be entered on the unit or home area count sheet supplied by the contracted pharmacy. In the Documentation section item #2 stated the shift to shift count must be completed and signed by one nurse going off shift and one nurse coming on shift.

Review of resident #001's narcotic record revealed on the counts for an identified medication, signatures from incoming nurse were missing for shift change counts on six identified dates. Signatures from outgoing nurse were noted on the count sheet for the above mentioned counts.

Interview with the administrator indicated that it was the home's expectation to have two nurses do the shift change count on the narcotic medication, and sign on the count sheet after conducting the count. The administrator confirmed that the home's policy was not complied with. [s. 8. (1) (b)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital.

Review of resident #001's progress notes revealed the resident had a fall incident on an identified date and time. The resident rang the call bell to be toileted. PSW #005 transferred the resident onto the toilet and left the room. Record review and staff interview indicated the resident got up from the toilet without using the call bell and fell. The PSW and RN #002 heard the resident calling for help and went into the washroom and found the resident on the floor. The resident was assessed and helped into bed, no obvious injury was documented. The resident was transferred to hospital in the next shift for further assessment as ordered by the attending physician. The resident returned to the home the same day with no acute injury identified. A test conducted 12 days later indicated possibility of an injury. A record review of critical incident revealed the fall incident resulting in an injury with transfer to hospital was not reported to the Director.

Interviews with the director of care (DOC) and administrator confirmed that the above mentioned critical incident was not reported to the Director. [s. 107. (3) 4.]

Issued on this 21st day of January, 2016

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

Original report signed by the inspector.