Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 6, 2019	2019_814734_0016	009641-18, 015550-18, 019236-18, 020294-18, 028451-18, 028576-18	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Scarborough
3830 Lawrence Avenue East SCARBOROUGH ON M1G 1R6

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

JADY NUGENT (734), AMANDEEP BHELA (746), DIANE BROWN (110)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 7-11, October 15-18 and October 21-23, 2019.

The following intake was inspected upon during this Critical Incident System inspection:
-log #009641-18, related to responsive behaviours;
-log #015550-18, related to safe and secure home;
-log #019236-18, staff related abuse;
-log #020294-18 and #028576-18 related to falls and
-log # 028451-18, related to critical incident response

A Complaint (CO) inspection was conducted concurrently with this Critical Incident System inspection.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspectors spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Facility Staff, Social Worker (SW) and residents. The inspectors also made observations of residents and their home areas; reviewed policies and relevant administrative health records for specified residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 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	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. (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, clear directions to staff and others who provide direct care to the resident.

A Critical Incident report was submitted to the Director regarding a fall resulting in an injury. The CIS report identified that resident #005 was found in their room (post fall) and complaining of pain, and was then transported to the hospital and later diagnosed with an injury.

Inspector #734 reviewed resident #005's electronic plan of care records and the licensee's Falls Management program. Based upon these records, resident #005 had a history of falls and was categorized as high risk for falls. The interventions listed various strategies, however, the intervention stating "ensure commonly used items (specify) are within easy reach" lacked the specifications of the item(s) being referred to.

During an interview with Registered Nurse (RN) #107 they were asked to review their recommendation in an assessment tool, which recommended the use of resident #005's care equipment as a falls prevention strategy. The RN stated that resident #005 was known to get up on their own to use the washroom during the night. The staff would provide interventions to the resident during that night, which included providing the resident with their care equipment within reach. This intervention was used to help

reduce the risk of falls. Inspector #734 then asked RN #107 if this specific care equipment was clearly stated in the care plan. The RN stated that the directions provided were not clear, as it was not specified. The RN went on to show Inspector #734 that following the said injury, the intervention was updated in the care plan to specify ensuring their care equipment was in reach.

In an interview with RN #103 they confirmed that the use of the care equipment at night was documented on an assessment form. However, there had not been an update to the care plan until after resident #005's injury. The RN was unable to provide a reason as to why this intervention had not been clearly stated in the care plan prior to the resident's critical incident.

In an interview with Director of Care (DOC) #118, they stated that it was the expectation of staff to implement their standard fall interventions when a resident presented with a history or high risk of falls. Inspector #734 provided the DOC a copy of the care plan prior to and after the injury; and the assessment in place at the time of the incident. In addition, the DOC was provided with other completed assessments. The DOC confirmed that the intervention in place at the time of the injury did not provide clear direction to staff. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised because the care set out in the plan was not being effective. The licensee failed to ensure that different approaches were considered in the revision of the plan of care.

A CIS report was submitted to the Director regarding a fall resulting in an injury. The CIS report identified that resident #006 was found in their room (post fall) complaining of pain. The resident was transported to the hospital and later diagnosed with an injury.

Inspector #734 reviewed the electronic plan of care records, the licensee's Falls Management program and maintenance request records for resident #006. Based on the records, risk screens were completed upon admission. The outcome of both these screening tools categorized resident #006 as a high risk of falls. The records also indicated that resident #006 had sustained two falls prior to the critical incident.

The two prior assessment outcome recommendations were to continue monitoring and to remind the resident to use the call bell for assistance. The fall related to the critical incident was assessed also using the same assessment tool. The recommendation

provided to help prevent future falls at the time of the critical incident was to implement a specified intervention.

In an interview with RN #107 confirmed that previous interventions used in the care plan did not seem to address the resident's fall risk. Additionally, RN #107 stated that based on the records it appeared that not much had been done to address further falls with the prior incidences.

In an interview RN #114 they confirmed that the use of a specified intervention was not present during resident #006's fall. RN #114 was unable to recall why such an intervention would not have been used, even though it would have been an intervention the team would normally implement. RN #114 offered the suggestion of a request possibly being made to maintenance via their request log book for the specified intervention, and the unit not receiving it. Inspector #734 then requested maintenance records for the nursing station for a specified period of time. The records showed no request for the specified intervention being made for resident #006.

In an interview with DOC #118 they identified that it would be the expectation that staff would implement their standard fall prevention interventions when a resident was considered to be high risk. The specified intervention would have been such an intervention. DOC #118 confirmed that there was no such request made in the maintenance log book for resident #006. DOC #118 also confirmed that the home failed to review and revise the care plan with different approaches as part of the care plan revisions. [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 that ensures each written plan of care sets out clear directions for staff and others providing care; and ensures that different approaches are considered when revising the plan of care, to be implemented voluntarily.

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director of an incident within 10 days of becoming aware of the incident, including the events leading up to the incident.

A CIS for unexpected death was submitted to the Director, describing an incident involving resident #013.

On a specified date, the Director requested further information related to resident's medical diagnosis, cognitive performance scale, resident transfer and ambulation status, location of resident prior to transfer and if staff completing transfer noted a change in the resident's status.

The CIS report submitted by Associate Director of Care (ADOC) #124 was not amended with the information requested by the Director.

Review of the CIS records further indicated that on a specified date, a Triage Inspector requested for the CIS to be amended and DOC #118 stated the CIS will be amended by end of day tomorrow.

A record review for a specified period of time, indicated that the amendment was still not received as requested.

An interview with DOC #118 confirmed that the home failed to make a report in writing to the Director of any incidents in r.107 (1), (3) or (3.1), within 10 days of becoming aware of the incident, that includes the events leading up to the incident. [s. 107. (4) 1.]

Issued on this 7th day of November, 2019

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

Original report signed by the inspector.