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 22, 2019	2019_594746_0020	008632-18, 015345-18, 019427-18, 003431-19	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 Scarborough
3830 Lawrence Avenue East SCARBOROUGH ON M1G 1R6

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

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

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): October 8, 10, 11, 15, 16, 17, 18, 21, 22, and 23, 2019.

Log #008632-18 related to plan of care.

Log #015345-18 related to authorization of admissions to the home.

Log #019427-18 related to management of responsive behaviours, plan of care, infection control, pain management and dealing with complaints.

Log #003431-19 related to abuse.

During the course of the inspection, the inspector conducted observations on staff to resident interactions, provisions of care, conducted reviews of health records and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Social Worker (SW), DOC clerk, Behavioural Supports Ontario Lead (BSO), Central East Placement Coordinator, Associate Director of Care (ADOC), and the Director of Care (DOC).

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

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

5 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

According to O. Reg. 79/10, s. 53(1) Every licensee of a long-term care home shall ensure that written approaches to care are developed to meet the needs of the residents with responsive behaviours that include screening protocols, assessment, reassessment, and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.

A review of the home's policy titled "Responsive Behavior Policy" #RC-17-01-04, last updated February 2017, directed nursing staff to complete referrals to the responsive behavior staff (BSO where available) if the use of the process maps of approach and/or redirection are unsuccessful to manage the resident's behavior and after initial investigation has been completed (i.e. investigating the possibility of a UTI or the resident having uncontrolled pain).

A review of the home's "Urinary Tract Infections in Long Term Care Clinical Pathway" provided to inspector by the DOC identified a practice point as follows: Residents who are cognitively impaired may not be able to verbalize symptoms of the identified diagnosis. Non-specific symptoms which may indicate the identified diagnosis include: worsening functional status, worsening mental status, increased confusion, delirium or agitation, falls (new or more often).

This IP was initiated related to a complaint, log #019427-18, whereby resident #002 was sent out to the hospital. The complainant alleged the hospital identified the resident with an identified diagnosis which the home failed to assess the resident for signs and symptoms of when demonstrating escalating behaviors which resulted in a transfer to hospital.

A review of the progress notes identified resident #002 was sent to the hospital on an identified date, related to escalating unmanageable behaviors. A further record review of the 'digital prescribers order form' identified resident #002 returning to the home on an identified date with a physician medication order with an identified diagnosis.

A record review prior to the incident on the identified date and staff interviews with RN #109 and RPN#103 identified the resident had behaviors with prescribed regular scheduled medication. The medication administration record system (MARS) identified a specific medication prescribed as 1 mg once daily 'as required for agitation'.

According to the progress notes dated over the course of three identified dates, resident #002 had been demonstrating aggressive responsive behaviours which escalated during this period of time. In the two days prior to the hospitalization on the identified date, the behaviour escalated.

The record review further indicated that there was no documentation to support that resident #002 was assessed for the identified diagnosis, as was the expectation according to the homes' policy.

An interview with BSO-RPN #101 shared that the resident's behaviors were escalating and because they had other identified symptoms, it would be hard to say if the resident had the additional symptoms related to the specific identified diagnosis, but that nursing staff should have assessed further and confirmed if there were other symptoms of the identified diagnosis. The RPN shared that the resident's behavior was escalating and between identified dates and the identified medication was being administered almost everyday for agitation. The RPN confirmed the documentation for an specified symptom on two identified dates and that an initial investigation for the identified diagnosis had not been completed as per policy.

An interview with full time day RPN #112 shared that back in an identified time period they were so frustrated with resident #002 they did not want to come to work. The RPN

stated that the resident had a lot of behaviors. The RPN shared that medication was administered because they could not control the resident. The staff shared that with the escalating behaviors they did assess one symptom but not for the identified diagnosis according to the home's policy.

The former BSO-RPN #108 stated that resident #002 had identified behaviors and was resistive to care. The BSO-RPN confirmed that they had not been referred during the identified time frame when the resident's behaviors had escalated nor had nursing completed an initial investigation into the escalation in keeping with the home's policy.

An interview with the DOC confirmed that the nursing staff should have completed an initial investigated when resident #002 had escalating behaviors and identified symptoms according to the home's policy Responsive Behavior #RC-17-01-04. The DOC shared that staff needed to stand back and assess what was going on with the resident. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute, or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure it is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of the resident that included any mood and behaviour patterns, including wandering; any identified responsive behaviours or any potential behavioural triggers and variations in resident functioning at different times of the day.

This IP was initiated related to a complaint, log #019427-18, whereby resident #002 was sent out to the hospital. The complainant alleged the hospital identified the resident with an identified diagnosis and the home failed to assess the resident for sign and symptoms of the identified diagnosis when demonstrating escalating behaviors which resulted in a transfer to hospital.

A record review of progress notes was conducted on an identified date and time by the BSO team RPN #108. The note documented that around an identified time, the writer RPN #108, was paged by the DOC. The documentation included the RPN #108 went up and observed the resident in their room. The resident was displaying behaviours, the resident was transferred to hospital for further assessment.

A record review of progress notes leading up to the events on the identified date, identified behavior notes whereby resident was displaying verbal and physical responsive behaviours. The behavior notes between identified dates related to resident's behaviours were reviewed.

A further review of progress notes between an identified time period identified 26 behavioral notes documenting verbally inappropriate comments and/or agitation.

An interview with full time day RPN #112 shared that during an identified time period they were so frustrated with resident #002 they did not want to come to work. The RPN shared the resident had a lot of behaviors. The RPN shared that the resident's identified triggers. The RPN confirmed the triggers were not identified in the resident's plan of care.

In an interview the former BSO- RPN #108 shared an identified trigger for resident #002; and that their behaviors usually started around an identified time. The staff confirmed that triggers were not identified in the resident's plan of care.

An interview with full time PSW #111 described resident #002 in and around an identified

timeframe where they had identified triggers.

An interview with full time days PSW #110 stated that you would not know a resident's behavioral triggers and strategies. The PSW stated they would try something and if it worked they would try it again and that they tried to figure it out.

An interview with the DOC confirmed that the resident's written plan of care did not include mood and behaviour patterns, all identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. [s. 26. (3) 5.]

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident, mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day is complied with,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible.

This IP was initiated related to a complaint, log #019427-18, whereby resident #002 was sent out to the hospital for further assessment. The complainant alleged the hospital identified the resident with an identified diagnosis and the home failed to assess the resident for signs and symptoms of the identified diagnosis when demonstrating escalating behaviors which resulted in a transfer to hospital.

A record review of progress notes on an identified date and time by the BSO team staff #108 related to resident #002's escalating behaviors and transfer to hospital.

The progress note on an identified date and time included documentation that, the writer, BSO-RPN #108, was paged by the DOC. Staff #108 went up and observed the resident in their room. The resident was demonstrating responsive behaviours. Resident was transferred to hospital for further assessment.

A review of progress notes between an identified period identified 26 behavioral notes documenting verbally inappropriate comments and/or agitation.

A further record review of progress notes leading up to the events of the identified date identified behavior notes whereby resident was demonstrating responsive behaviours. A progress note identified a BSO Team meeting on an identified date whereby changes to

the resident's medication were recommended and staff recommended interventions.

A record review of the resident's written plan of care prior to the hospital transfer was conducted. The plan of care identified two interventions.

A record review and staff interviews with RN #109 and RPN#103 identified the resident was prescribed regular scheduled medication for behaviors. The MARS further identified one medication prescribed 1 mg once daily "as required".

An interview with FT PSW #111 described resident #002's behaviors in and around the July 2018 time. The staff shared that when they provided care to the resident their approach was to tell the resident that before being placed to bed for rest they first had to be changed. When asked what interventions were in place to manage the resident's behaviors the staff shared they would just try different things and that they had to negotiate with them.

An interview with full time days PSW #110 stated that they would not know a resident's behavioral triggers and strategies. The PSW stated they would try something and if it worked they will try it again or they just tried to figure it out. PSW #110 shared they had a good rapport with the resident and that the resident liked to be called an identified name and when they spoke to them in this manner they would listen. The PSW shared that they could not use a specific identified word.

An interview with full time day RPN #112 shared that during an identified time period they were so frustrated with resident #002 they did not want to come to work. The RPN shared that the resident had a lot of physical and verbal behaviors. The RPN identified that the strategies were not identified in the resident's written plan of care prior to the identified date of transfer to hospital.

An interview with RN #109 shared that the identified PRN medication would be used once they heard the resident was exhibiting responsive behaviours. The RN stated they would give it right away if they did not the resident's behaviors could get worse. RN #109 responded that they sometimes would complete an identified form for residents with escalating behaviors and that resident #002 had a lot of behaviors and was receiving medication. The RN shared that they would have the doctor reassess the resident's medication when a resident presented with escalating behaviors.

An interview with BSO-RPN #101 shared that the identified medication was not effective

for the resident's agitation as it was used almost daily during an identified time period when the resident was sent to the hospital related to escalating behaviors. The RPN shared that other interventions were not developed and implemented other than medication according to the resident's plan of care.

An interview with BSO-RPN #108 identified that the interventions for behaviors in the home were more chemical and that a chemical approach does not solve the problem. The staff shared that a PRN medication like the identified medication should be a last resort. The staff was familiar with resident #002. The BSO-RPN stated that resident #002 had behaviors and that interventions were not identified in the resident's plan of care.

An interview with the DOC identified that there were a number of different strategies that were available in the home to manage a resident with responsive behavior and that the identified medication was a chemical restraint. The DOC confirmed that resident #002' plan of care did not include identified strategies to be implemented to respond to the resident's behaviors. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee shall ensure that, for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified, where possible, strategies are developed and implemented to respond to these behaviours, where possible; and actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.is complied with,, to be implemented voluntarily.

WN #4: 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

This IP was initiated related to complaint log #019427-18.

A record review of resident #002's 'Medication Review (Chart) Report' during an identified time period identified an order for an identified medication PRN. The order for the identified medication was written 0.5mg Tab by mouth (PO)-PRN take 1 or 2 tablets (0.5-1mg) by mouth once daily as needed for agitation.

A record review of the resident's MARs during an identified period, identified the same order as 1 mg tab by mouth- order date July 28, 2017. ½ or 1 tablet (0.5mg-1mg) PO once daily as required for agitation.

A review of the MARS for an identified period identified that the identified drug had been administered twice daily on five identified dates by RN #109.

An interview with RN #109 confirmed the drug has been given twice daily and that they thought the order was twice a day (BID) as needed.

An interview with the DOC confirmed that the drug had not been administered to resident #002 in accordance with the directions for use specified by the prescriber. [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 the licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

1. The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to applicant #012's withholding of authorization for admission to home's Convalescent Care Program.

The licensee has failed to comply with section 44(7) of the LTCHA whereby the licensee refused the application for applicant #012 for reasons other than provided for in the LTCHA. In addition, the licensee's response to the applicant failed to contain all of the required elements of section 44(9).

The Ministry of Long-Term Care (MLTC) received a complaint on an identified date, related to applicant #012's withholding of approval for admission to Extendicare Scarborough's Convalescent Care Program.

The response letter dated on an identified date, signed by the home's ADOC included details on the applicant's current health conditions and concluded that the applicant would not be able to satisfy the requirements, and intensity of the rehabilitation program. The home was unable to provide Inspector with the applicant #012's application.

In a telephone interview with Admissions Coordinator #125 who had been involved with applicant #012, identified that the applicant would have been successful in the program.

An interview with Social Worker #104 identified that the ADOC and Physiotherapist were involved with reviewing the application, both of whom no longer work at the home.

An interview with DOC #118 was conducted on an identified date. When questioned as to the reason for the refusal, DOC #118 referred to the notes on the home's letter and stated that the applicant did not fit the criteria based on the applicant's health condition therefore, the applicant would not be successful in the home's Convalescent Care Program.

The licensee's reasons for witholding the admission to applicant #012 did not meet legislative requirements. [s. 44. (7)]

2. A record review was completed of home's response letter withholding the admission of resident #012.

The response letter dated on an identified date, signed by the home's ADOC included details on the applicant's current health conditions and concluded that the applicant

would not be able to satisfy the requirements, and intensity of the rehabilitation program. The home was unable to provide Inspector with the applicant #012's application.

An interview with DOC #118 was conducted on an identified date. When questioned as to the reason for the refusal, DOC #118 referred to the notes on the home's letter and stated that the applicant did not fit the criteria based on the applicant's health condition therefore, the applicant would not be successful in the home's Convalescent Care Program.

The licensee's reasons for witholding the admission to applicant #012 did not meet legislative requirements. [s. 44. (9)]

Issued on this 26th day of November, 2019

[redacted]

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

Original report signed by the inspector.