Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 22, 2021	2021_725522_0003	022773-20, 022791-20, 024918-20, 002360-21, 002381-21	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 Southwood Lakes
1255 North Talbot Road Windsor ON N9G 3A4

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

JULIE LAMPMAN (522)

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): March 1, 2, 3, 4, 5, 8, 9, 10, 11, 15, 16, 17, 18, 19, 22, and 23, 2021.

The following intakes were inspected during this inspection:

Log #020118-20 Follow-up to Compliance Order (CO) #001 from inspection #2020_563670_0032 related to the home's skin and wound program;

Critical Incident System (CIS) report #2842-000032-20/Log #022773-20 related to alleged staff to resident abuse;
CIS #2842-000036-20/Log #024918-20 related to falls prevention;
CIS #2842-000008-21/Log #002360-21 related to resident to resident abuse;
CIS #2842-000009-21/Log #002381-21 related to resident to resident abuse.

PLEASE NOTE:
A Voluntary Plan of Correction (VPC) related to O. Reg 79/10 s. 6. (1) (c) identified in Complaint Inspection #2021_725522_0004, which was conducted concurrently with this inspection, has been issued in this inspection report.

A VPC related to O. Reg 79/10 s. 30. (1) 2 identified in Complaint Inspection #2021_725522_0004 has been issued in this inspection report.

A Written Notification related to O. Reg. 79/10, s. 8 (1) (b) was issued in this inspection as supporting evidence for CO #001 issued in inspection #2020_563670_0032 with a compliance due date of February 9, 2021.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Care Coordinator, Nutritional Manager, Program Manager, Social Worker, Registered Dietitian, Nursing Clerk, Resident Assessment Instrument Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), a Behavioural Supports Ontario PSW, an Agency PSW, a Housekeeper, a Recreation Staff, a Security Guard/Screener, a Windsor Essex County Public Health Inspector, residents and family members.

The inspector also observed staff to resident interactions, resident to resident interactions, infection prevention and control practices in the home, the provision of resident care, reviewed resident clinical records, skin and wound audits, staff training, the home's program evaluations and policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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

9 WN(s)
6 VPC(s)
1 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 the home's "Falls Prevention and Management Program" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Review of Extendicare's "Falls Prevention and Management Program" policy indicated for 72 hours post-fall, staff were to assess the resident at each shift and document the results of all assessments and actions taken during the 72 hour post-fall follow-up.

If a resident hit their head or was suspected of hitting their head (e.g. unwitnessed fall) a Clinical Pathway Monitoring was to be completed.

For 72 hours post-fall, staff were to assess the resident at each shift and document the results of all assessments and actions taken during the 72-hour post-fall follow-up.

Review of the home's "Clinical Monitoring Record" stated staff were to monitor resident's neurovital signs every hour x 4 hours then every 8 hours x 72 hours, if a head injury was suspected or the fall was unwitnessed.

Review of Extendicare's "Falling Star/Leaf Flagging Guide" noted the purpose of the

Falling Star/Falling Leaf Program was to identify residents at risk for falls or falls injuries and clearly communicate to staff and other care team members' standard interventions for reducing risk. Residents would be identified by an icon on their bedroom door or near their bed.

A) Review of resident #008's post fall assessments noted the resident had four unwitnessed falls over three months.

i) Review of resident #008's Clinical Monitoring records for two falls, noted missing documentation. Registered Practical Nurse (RPN) #128 confirmed the missing documentation on each record and stated that staff were to document for the required time frames, unless a resident refused which should be documented.

Inspector #522 and the Director of Care (DOC) were unable to locate resident #008's Clinical Monitoring record for one of the other falls. The DOC stated a Clinical Monitoring record should be completed after every unwitnessed fall.

ii) Review of resident #008's progress notes noted the absence of 72 hour post-fall documentation on several shifts for two falls.

The DOC reviewed resident #008's progress notes and acknowledged the missing 72 hour post-fall documentation. The DOC stated post-fall monitoring should be documented in resident #008's progress notes each shift for 72 hours.

B) Review of resident #010's post-falls assessments noted resident #010 had four unwitnessed falls over a one month period.

i) Review of resident #010's Clinical Monitoring records for the four falls noted missing documentation.

Interviews with Registered Nurse (RN) #124 and Registered Practical Nurse (RPN) #128 confirmed the missing documentation on each record. RPN #128 stated staff were to document for the required time frames, unless a resident refused or the resident had another fall and a new Clinical Monitoring record was initiated, which should be documented.

ii) Resident #010 was observed in their room laying in bed. There was no falls logo observed in their room.

PSW #116 observed resident #010's room and acknowledged there was no falls logo at resident #010's bedside and there should be as resident #010 was a high falls risk.

iii) Review of resident #010's progress notes for 72 hour post-fall monitoring for one fall noted documentation missing on one shift.

The DOC reviewed resident #010's progress notes and acknowledged the missing 72 hour post-fall documentation. The DOC stated clinical monitoring should be completed in full for all unwitnessed falls and post-fall monitoring should be documented in resident #010's progress notes each shift for 72 hours. The DOC stated as part of falls prevention falling leaf signage should be posted above a resident's bed.

C) Resident #012 had numerous falls over a two month period.

i) A review of resident #012's progress notes noted the absence of documented 72 hour post-fall progress notes for two specific falls. A progress note was missing for one shift for three specific falls.

In an interview, RPN #125 stated they audited that post-falls assessments were completed but did not check that staff completed the 72 hours post-fall checks. RPN #125 stated staff would know to complete checks as it was on report to complete 72 hour post-fall monitoring. They stated they had spoken with staff as staff were only doing 72 hours post-fall checks for unwitnessed falls and 24 hour post-fall checks for witnessed falls.

ii) Review of resident #012's hard copy Clinical Monitoring records, noted seven unwitnessed falls that did not have a Clinical Monitoring record completed and six falls where the Clinical Monitoring record was not completed in full.

In an interview, RN #124 stated they were unable to locate resident #012's missing Clinical Monitoring records. RN #124 acknowledged all records should have the date on them and acknowledged records should be completed in full and they were not.

iii) Observation of resident #012's room noted no falls logo at resident #012's bedside. This was confirmed by RN #124 and Personal Support Worker #113.

The DOC reviewed resident #012's progress notes and acknowledged the missing 72

hour post-fall documentation. The DOC stated clinical monitoring should be completed in full for all unwitnessed falls and post-fall monitoring should be documented in resident #012's progress notes each shift for 72 hours. The DOC stated as part of falls prevention falling leaf signage should be posted above a resident's bed.

The home's failure to follow their "Falls Prevention and Management Program" policy and "Clinical Monitoring Record" placed residents #008, #010 and #012 at risk as staff had the potential to miss post fall injuries if regular assessments were not completed. The home's failure to follow their "Falling Star/Leaf Flagging Guide" put residents #010 and #012 at risk as they were not flagged as a falls risk for staff who did not know them.

Sources:
Observations of resident #008, #010 and #012's rooms, resident #008, #010 and #012's clinical records, Extendicare's "Falls Prevention and Management Program" policy RC_15-01-01 last updated August 2019, Clinical Monitoring Record RC -15-01-01 A6 last updated August 2019 and Extendicare's Falling Star/Leaf Flagging Guide RC -15-01-01 A4 last updated August 2019, interviews with PSW #113, PSW #116, RN #124, RPN #120, RPN #123, RPN #125, RPN #130, and the DOC.

D) Review of Extendicare's "Falls Prevention and Management Program" noted in part that each home would designate one or more Falls Program Leads to act as clinical champions and coordinate key aspects of the program.

Extendicare's "Falling Star/Leaf Flagging Guide" noted in part that the Falls Program Lead would review the Falling Star/Leaf Program regularly (e.g. weekly) to ensure program identifiers were up-to-date, and conduct spot checks to ensure interventions were consistently and appropriately applied.

Review of Extendicare's "Post Fall Clinical Pathway" noted in part that after a resident fall registered staff were to refer to the interdisciplinary team members/and or Fall committee for further follow-up as needed.

In an interview, the DOC stated the Falls Program Lead used to be RPN #130 and now RPN #125 was helping. The DOC stated they should meet regularly to review and analyze falls along with the Clinical Care Coordinator (CCC), RPN #130 and RPN #131. The DOC stated they were going to ask RPN #125 and RN #108 to attend also. The DOC stated they did not meet for a while due to COVID-19 and now they would get together.

The DOC stated they did not meet with the team to review the number of falls resident #012 had and interventions in place but believed RPN #130 and RPN #131 did. The DOC stated they did want to meet and involve the doctor prior to resident #012's care conference.

In an interview, the CCC stated there were no regular falls meetings, but they did look at falls at morning management meetings. The CCC stated that everyone was responsible for the falls program in the home and that the CCC, RPN #130, the DOC would be considered the leads of the program.

In interviews, RPN #125, RPN #130 and RPN #131 all stated they were not currently involved in the falls committee, other than RPN #125 who completed audits of post fall assessments to ensure they were completed properly. The RPNs stated since the pandemic there had not been a falls committee or meetings and they did not know who the Falls Program Lead was.

The RPNs and RN #108 stated they had not been involved in any interdisciplinary meetings regarding falls prevention for resident #012 who had numerous falls in a two month period.

Resident #012 was at risk for injury when the home did not follow their Falls Prevention and Management Program policies by having a clearly designated Falls Program Lead and an interdisciplinary or Falls Committee review of resident #012's numerous falls.

Sources:
Extendicare's "Falls Prevention and Management Program" RC_15-01-01 last updated August 2019, Extendicare's "Falling Star/Leaf Flagging Guide" RC -15-01-01 A4 last updated August 2019 and Extendicare's "Post Fall Clinical Pathway" RC-15-01-01-A5 last updated August 2019 and interviews with the DOC, CCC, RN #108, RPN #125, RPN #130 and RPN #131.

2. The licensee has failed to ensure that the home's Skin and Wound Program: Wound Care Management" policy was complied with for resident #014 and #015.

O. Reg. 79/10 s. 48 (1) 2. States, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A skin and wound care program to promote skin integrity, prevent the

development of wounds and pressure ulcer, and provide effective skin and wound care interventions."

Review of Extendicare's "Skin and Wound Program: Wound Care Management" policy noted in part that a resident exhibiting any form of altered skin integrity would receive specified care as set out in the plan of care and the resident's treatment regimen would be recorded on the electronic Medication Administration Record (eMAR) and/or electronic Treatment Administration Record (eTAR).

Review of the home's "Altered Skin Integrity Clinical Pathway" noted for altered skin integrity staff were to initiate a weekly Treatment Administration Record (TAR) for ongoing skin integrity assessments.

A) A skin assessment noted resident #014 had a new area of altered skin integrity. The assessment indicated a specific intervention for resident #014 to prevent further skin breakdown.

Review of resident #014's eTAR noted no documentation to assess the area of altered skin integrity weekly.

Review of resident #014's care plan noted a skin focus for the area of altered skin integrity had been created almost one month after the initial skin assessment. The intervention included in the initial skin assessment was not included in resident #014's care plan.

In an interview, Registered Practical Nurse (RPN) #130 acknowledged they created the skin focus in resident #014's care plan after the skin issue was resolved. RPN #130 acknowledged the care plan was to be updated when skin integrity issues were identified. RPN #130 stated they noticed the care plan was not completed when they did their skin and wound audit and entered it into the care plan at that time.

RPN #130 reviewed resident #014's eMAR/eTAR and acknowledged that there was no documentation that the area of altered skin integrity was to be assessed weekly. RPN #130 stated all areas of altered skin integrity should be added to the eTAR for reassessment other than pressure ulcers as they were done by the skin and wound nurse.

B) Review of resident #015's progress notes noted resident #015 had an area of altered

skin integrity.

A weekly impaired skin integrity assessment, which was locked just over two weeks after the area of altered skin integrity was identified and noted as completed, noted resident #015 had an area of altered skin integrity that was healed. The progress note auto populated by the skin assessment noted the assessment had been backdated.

There were no other skin and wound assessments of resident #015’s altered skin integrity.

Review of resident #015's eTAR noted a treatment had not been created for weekly assessments of resident #015’s area of altered skin integrity.

In an interview, RPN #130 acknowledged that the assessment was completed as a late entry. RPN #130 stated the assessment should have been completed on the day the area of altered skin integrity was noted and that it was likely when the weekly skin and wound audit was completed that the RPN was notified and inputted it as a late entry and had to entered 'healed' as the area had healed at that time.

RPN #130 reviewed resident #015’s eMAR/eTAR and noted that weekly assessments of the area of altered skin integrity had not been entered and that it should have been entered when the area of altered skin integrity occurred.

The home's failure to follow their "Skin and Wound Program: Wound Care Management" policy placed resident #014 and #015 at risk of worsening skin integrity issues.

Sources:
Resident #014 and #015’s clinical records, Extendicare’s “Skin and Wound Program: Wound Care Management” policy RC-23-01-02 last updated August 2019, the home’s “Altered Skin Integrity Clinical Pathway” dated December 2020, the home's weekly impaired skin integrity audits, interviews with RPN #130 and the Director of Care.

3. The licensee has failed to ensure that the home's “Skin and Wound Program: Wound Care Management” policy was complied with for resident #008 and #012.

This finding of noncompliance is further evidence to support compliance order #001 that was issued on November 12, 2020, during Complaint Inspection #2020_563670_0032 with a compliance due date of February 9, 2021.

A) Review of resident #008's progress notes noted a Personal Support Worker (PSW) had reported that resident #008 had an area of altered skin integrity.

Inspector was unable to locate documentation of a skin and wound assessment for resident #008's area of altered skin integrity or weekly assessments in the resident's electronic Treatment Administration Record (eTAR).

In an interview, RPN #121 acknowledged a PSW had reported to them that resident #008 had an area of altered skin integrity. RPN #121 confirmed they did not complete a skin and wound assessment of the area and acknowledged they should have. RPN #121 stated they were also to put weekly skin integrity assessments on the resident's eTAR.

B) Resident #012 had several areas of altered skin integrity.

Review of resident #012 's Head to Toe Skin Assessment noted several areas of altered skin integrity with the exception of one area.

An initial skin assessment was completed for all but one area of altered skin integrity and there were no further documented skin assessments.

The only documented skin assessment for the area of altered skin integrity that had not been included on the Head to Toe Assessment, was when the area had healed.

Review of resident #012's eTAR noted a treatment had not been created for weekly assessments of any of the areas of altered skin integrity.

RPN #130 reviewed resident 012's assessments and noted there were no assessments of the areas of altered skin integrity. RPN #130 stated registered staff were to enter in the resident's eTAR if the resident had altered skin integrity and when the skin and wound assessments were to be completed.

The Director of Care (DOC) reviewed resident #012's skin and wound assessments and head to toe assessment. The DOC stated the one area of altered skin integrity should have been included in the head to toe assessment. The DOC stated weekly skin and wound assessments should be completed for resident #012's areas of altered skin integrity and an assessment should also be completed to indicate when the impaired skin integrity healed.

The home's failure to follow their "Skin and Wound Program: Wound Care Management" policy placed resident #008 and #012 at risk of worsening skin integrity issues.

Sources:
Resident #008 and #012's clinical records, Extendicare's "Skin and Wound Program: Wound Care Management" policy RC-23-01-02 last updated August 2019, the home's "Altered Skin Integrity Clinical Pathway" dated December 2020, interviews with PSW #117, RPN #121, RPN #130, Clinical Care Coordinator and the Director of Care. [s. 8. (1) (a),s. 8. (1) (b)]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents when resident #002 was not isolated when they were in a semi-private room with a shared a bathroom with resident #001 who was on droplet and contact precautions.

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007 stated in part:
"...residents who have not been previously cleared of COVID-19 must remain in isolation under Droplet and Contact Precautions for a 14-day period following arrival."

"Individuals must be placed in a single room on admission to complete their 14-day self-isolation. Where this is not possible, individuals may be placed in a room with no more than one (1) other resident who should also be placed in isolation under Droplet and Contact Precautions."

Resident #001 was observed in their room with droplet and contact precaution signage posted outside their room. Resident #001's room had a shared bathroom with resident #002, who shared the semiprivate room. Resident #002 was not in the room.

Review of resident #001's electronic clinical records noted resident #001 was in isolation under droplet and contact precautions.

Review of resident #002's electronic clinical records noted no documentation that resident #002 was in isolation under droplet and contact precautions.

In an interview, Personal Support Worker #107 stated resident #002 was not in isolation under droplet and contact precautions. This posed risk to residents as resident #001 could have potentially been incubating COVID-19 and there was the potential of transmission of the COVID-19 virus between resident #001 and resident #002, who was interacting with other residents and staff members.

In an interview with the Director of Care (DOC) and Clinical Care Coordinator (CCC), the DOC acknowledged that if a private room was not available, the home's usual practice was to place a new admission in a semiprivate room and assign one resident the bathroom. When asked about the risk to resident #002, the CCC acknowledged that there was potential risk for cross contamination from resident #001 to resident #002.

Inspector reviewed Directive #3 with the DOC and CCC. The DOC acknowledged the home was not following Directive #3 issued by the Chief Medical Officer of Health.

In an interview, Windsor Essex County Public Health (WECPH) Inspector stated if a resident was admitted to a semiprivate room with a shared bathroom, both residents would need to be in isolation under droplet and contact precautions.

Sources:

Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, observations of resident #001 and #002's room, clinical records for resident #001 and #002, interviews with PSW #117, the DOC, the CCC and a WECPH Inspector. [s. 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 the home is safe and secure for its residents by placing both residents in a semi private room with a shared bathroom on droplet and contact precautions when one of the residents is in isolation, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. A) The licensee failed to ensure that resident #005's plan of care provided clear direction regarding contact precautions.

During an Infection and Prevention Control (IPAC) tour of the home, Inspector #522

observed resident #005's room with an isolation caddy on the door. There was no signage posted to instruct visitors or staff what precautions resident #005 was on.

In an interview, Registered Practical Nurse (RPN) #104 stated resident #005 was on contact precautions. Inspector asked if there was signage for staff regarding what precautions to take with resident #005. RPN #104 stated staff would know because of the isolation caddy on the door. Inspector asked how agency staff would know and RPN #104 stated their PSW partner would inform them. RPN #104 stated they could put signage up on the resident's door.

Review of resident #005's electronic care plan noted resident #005 was on contact precautions.

In an interview, Recreation Staff #112 stated they would know what type of precautions a resident had by signage on the resident's door, Point Click Care or the nurse would let them know.

In an interview, the Director of Care (DOC) and IPAC Lead/Clinical Care Coordinator (CCC) stated resident #005 was on contact precautions. The CCC acknowledged there should be contact precaution signage but that all staff should do a point of care risk assessment before contact with every resident.

The lack of contact precaution signage on resident #005's door posed a risk to resident #005. Contact precautions were additional precautions to routine precaution practices and without signage at the resident's room visitors and staff could enter without proper personal protective equipment putting resident #005 at risk.

Sources:
IPAC tour of the home, observation of resident #005's room, resident #005's clinical records, Extendicare's "Contact Precautions" policy #IC-03-01-10 dated October 2019, specific IPAC policies and interviews with RPN #104, Recreation Staff #112, a Windsor Essex County Public Health Inspector, the DOC and IPAC Lead/CCC.

B) The licensee failed to ensure that resident #013's plan of care provided clear direction to staff related to the use of a specific device to prevent skin breakdown.

Review of resident #013's progress notes noted resident #013 used a specific device to prevent skin breakdown.

Review of resident #013's most recent care plan noted no documentation that resident #013 was to use the device. This posed a risk to resident #013 as new staff may not be aware that the resident used the device to prevent skin breakdown.

In an interview, the Director of Care (DOC) reviewed resident #013's care plan and acknowledged that it did not include the use of the specific device to prevent skin breakdown. The DOC stated the use of the specific device should be included in resident #013's care plan. The DOC stated everyone was responsible to update a resident's care plan.

Sources:
Resident #013's clinical records and interview with the DOC.

C) The licensee failed to ensure that resident #010's plan of care set out clear directions to staff and others who provided direct care to the resident.

On several occasions resident #010 was observed using an assistive device.

Review of resident #010's progress notes indicated resident #010 used the assistive device due to a decrease in mobility and due to resident #010's increased risk for skin breakdown, a specific device was to be used.

Review of resident #010's care plan and kardex noted no documentation that resident used a the assistive device for mobility and the specific device to prevent skin breakdown.

In an interview, Personal Support Worker (PSW) #117 stated resident #010 had used the assistive device for over a month.

Registered Nurse (RN) #124 reviewed resident's care plan and kardex and acknowledged the use of an assistive device was not in the resident's plan of care and should be.

The Director of Care (DOC) stated the use of a specific device to prevent skin breakdown should be included in a resident's plan of care and it was everyone's responsibility to ensure a resident's care plan was updated.

This posed a risk to resident #010 as new staff may not be aware that the resident used an assistive device for mobility and a specific device to prevent skin breakdown.

Sources:
Resident #010's clinical record, observations of resident #010 and interviews with PSW #113, PSW #116, PSW #117, RN #124 and the DOC.

D) The licensee failed to ensure that resident #012's plan of care set out clear directions to staff who provided direct care to the resident.

On several occasions resident #012 was observed using an assistive device with specific falls interventions in place and a specific device to prevent skin breakdown.

Review of resident #012's progress notes indicated resident #012 used an assistive device with a specific device to prevent skin breakdown.

Review of resident #012's plan of care noted the absence of documentation related to the use of an assistive device, specific falls interventions in place and the use of a specific device to prevent skin breakdown.

In an interview, PSW #113 stated information related to a resident's care needs was in the resident's kardex or Point of Care. PSW #113 and RPN #123 stated there were specific falls interventions in place for resident #012.

RPN #123, RN #124 and PSW #117 confirmed the falls interventions in place for resident #012 were not in resident #012's plan of care and should be.

In an interview, the DOC confirmed the use of an assistive device and a specific device to prevent skin breakdown were not in resident #012's care plan and stated they should be part of resident #012's care plan. The DOC stated falls prevention interventions should be in a resident's care plan and all staff were to keep the care plan up to date.

This posed a risk to resident #012 as new staff may not be aware of the falls interventions in place for resident #012 and that resident #012 used a specific device to prevent skin breakdown.

Sources:
Resident #012's clinical record, observations of resident #012 and interviews with PSW

#113, PSW #117, Agency PSW #122, RPN #123 RN #124 and the DOC. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #012's SDM had been provided the opportunity to participate fully in the development and implementation of resident #012's falls prevention plan of care.

Resident #012 had a number of falls over a two month period.

Review of falls progress notes and post falls assessments for several of the falls noted to prevent further falls the resident required a specific intervention.

In interviews, RPN #120 and RPN #123 stated resident #012 needed a specific intervention to prevent falls as the resident was not safe. The RPNs indicated that they had told management resident #012 required the specific intervention.

In an interview, the DOC stated resident #012 did not have the specific intervention as the Ministry did not cover the specific intervention for falls prevention.

When inspector asked the DOC if there had been discussion with resident #012's family about having the specific intervention put in place, the DOC stated they would be meeting with resident #012's family soon.

Not involving resident #012's family in the development and implementation of the resident's falls prevention plan of care, in particular the specific intervention staff had indicated, placed resident #012 at risk due to the number of falls resident #012 had.

Sources:
Resident #012's clinical records, observations of resident #012 and interviews with RPN #120, RPN #123 and the DOC. [s. 6. (5)]

3. The licensee has failed to ensure care provided to residents #008, #010 and #012 was documented.

A) Review of resident #008's plan of care noted staff were to monitor resident #008.

Review of resident #008's Point of Care (POC) documentation in the home's Documentation Survey report noted staff were to monitor the resident #008 over a specific time frame.

Documentation was missing on several occasions over a two month time period.

B) Review of resident #010’s plan of care noted the resident was to have specific falls prevention interventions in place.

Review of resident #010's POC Documentation Survey report noted documentation of the falls prevention measures was missing on several occasions over a one month time period.

C) Review of resident #012’s plan of care noted staff were to monitor resident #012. Review of resident #012’s POC documentation in the home's Documentation Survey report noted staff were to monitor the resident over a specific time frame. Specific falls prevention measures were not added to POC until three months after their first fall. Documentation was missing on several occasions over a three month time period.

The DOC reviewed resident #008, #010 and #012’s documentation survey reports with inspector and acknowledged the missing documentation and stated PSWs should be documenting resident monitoring and falls interventions.

Missing documentation regarding resident #008, #010 and #012 puts the resident at risk as the documentation is not consistent to accurately reflect how the resident is doing with interventions in place.

Sources:
Resident #008 #010 and #012’s clinical records and interviews with the DOC. [s. 6. (9) 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 to ensure the resident's plan of care provides clear direction to staff; that care provided as per the plan of care is documented and that a resident's SDM is provided the opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure resident #011 and resident #010 were protected from resident #009.

A) On a specific date, Personal Support Worker (PSW) #113 witnessed an incident of abuse involving resident #009 to resident #011.

Review of resident #009's clinical records noted resident #009 had a history of behaviours.

Review of resident #009 and #011’s progress notes noted two previous incidents of abuse involving resident #009 to resident #011.

Resident #011 was assessed after each incident and it was noted there were no injuries to resident #011 and the resident did not recall the incidents.

In an interview, Registered Practical Nurse (RPN) #114 stated resident #009 initiated the abuse.

Review of all three incidents noted police had not been notified of any of the incidents.

In an interview, PSW #113 acknowledged they witnessed the incident of abuse involving resident #009 to resident #011. PSW #113 stated they assisted resident #011 after the incident and resident #011 did not know what had happened.

In an interview, Registered Nurse (RN) #124 stated they spoke with resident #011 after each incident and each time resident #011 did not recall what had happened to them. RN #124 stated they would only call police for an incident of this specific type of abuse if there was an injury to the other resident.

In an interview, the Director of Care (DOC) stated they did not call police for this specific type of abuse if there were no injuries as the police either asked the home why they were calling, came but did not see the resident, or just gave a report number. The DOC stated the police were not called for the incidents between resident #009 and resident #011 as there was no injury to resident #011.

B) On the same date as the incident with resident #011, RPN #114 observed an incident of abuse involving resident #009 to resident #010.

Review of resident #009’s care plan noted there were specific interventions in place due to their behaviours.

A debrief note after the incident with resident #010 noted interventions in resident #009’s care plan were not successful.

In an interview, RPN #114 stated they knew resident #009 had a history of behaviours and when they saw that resident #009 was beside resident #010 they went to check on resident #010 and noticed the abuse from resident #009.

Residents #011 and #010 and other residents were at risk due to resident #009's behaviours.

Sources:
Critical Incident System reports, clinical records for residents #009, #010 and #011, and interviews with PSW #113, PSW #118, RPN #119, RPN #114, RN #124, the Social Worker and the DOC. [s. 19. (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 to ensure residents are protected from abuse from resident #009, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the assistive devices used by staff, were appropriate for resident #013 and resident #010.

A) Review of resident #013's progress notes indicated resident #013 fell as their assistive device did not have the appropriate supports on it. The incident progress note stated staff were instructed to use the supports for the assistive device.

An assessment note stated resident #013 was to use the assistive device with specific supports.

In an interview, PSW #105 stated resident #013 had refused to have the specific supports applied to their assistive device and this had caused the resident to fall.

Review of resident #013's progress notes and care plan noted no documentation before the incident that resident #013 had refused to have the specific supports applied to their assistive device.

In an interview, Registered Nurse (RN) #108 stated resident #013 should have had the specific supports applied to their assistive device and did not recall that the resident would refuse to use the supports.

In an interview, the Director of Care (DOC) stated resident #013 should have had the specific supports applied to their assistive device. The DOC stated if the resident refused the supports it should have been reported and there should have been discussion with staff and documentation.

The staff's failure to use specific supports on resident #013's assistive device put resident #013 at risk for serious injury when they fell.

B) Resident #010 was observed using an assistive device which did not have specific supports in place.

Review of resident #010's progress notes indicated resident #010 had been assessed and was to use the assistive device with specific supports.

Registered Practical Nurse (RPN) #119 observed resident #010 with Inspector #522. RPN #119 stated that it was unsafe for resident #010 to not have the supports in place on their assistive device.

Personal Support Worker (PSW) #113 stated resident #010 usually used the specific

supports on their assistive device but they did not put them on. PSW #113 stated they thought the supports were not currently being used.

RPN #119 instructed PSW #113 to put the specific supports on resident #010's assistive device as the resident was unsafe without them.

Sources:
Resident #013 and resident #010's clinical records, observations of resident #010 and interviews with PSW #105, PSW #113, RPN #106, RPN #119, RN #108 and the DOC. [s. 30. (1) 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 where required, assistive devices used by staff are appropriate for residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when resident #012 had been assessed by the registered dietitian changes made to their nutrition plan of care had been implemented.

On a specific date, the Registered Dietitian (RD) assessed resident #012 and ordered a nutritional intervention as resident #012 was a high nutritional risk.

Two moths later, the RD assessed resident #012 due to altered skin integrity and noted resident #012 continued to receive the nutritional intervention.

Review of resident #012's clinical record and electronic Medication Administration Record (eMAR) for the two month period, noted the nutritional intervention was not indicated on resident #012's eMAR.

In an interview, the RD confirmed due to COVID-19 they were not in the home and would write orders and email them to the Nutrition Manager to give to the nurse. The RD confirmed they had ordered a nutritional intervention on a specific date for resident #012 and discontinued it two months later. The RD reviewed resident #012's electronic clinical record and confirmed an order for the nutritional intervention was not written and added to resident #012's eMAR. The RD stated the nutritional intervention should have been implemented for resident #012 when they ordered it as resident #012 was a high nutritional risk.

In an interview, Registered Nurse (RN) #108 reviewed resident #012's hard copy chart and confirmed there was no written order for the nutritional intervention. RN #018 stated either staff did not get the order or someone forgot to process the order. RN #108 stated staff should also review the dietitian's notes so staff would see what was ordered for resident #012.

Resident #012 was at risk for weight loss and delayed healing of altered skin integrity by not receiving the nutritional intervention as ordered.

Sources:
Resident #012's clinical record and interviews with the RD, RN #108, RN #109, the Nutrition Manager and Clinical Care Coordinator. [s. 50. (2) (b) (iii)]

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 when a resident is assessed by the registered dietitian changes made to their nutrition plan of care are implemented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs were stored were kept locked at all times, when not in use.

Inspector #522 observed a medication cart unlocked and unattended in the hallway. Inspector #522 waited several minutes and noted the registered staff member was with a resident in their room and had their back to the door. The medication cart was not visible from the resident room and a resident was noted walking with their walker in the hallway.

When Registered Practical Nurse (RPN) #121 came out of the resident's room they acknowledged they had left the medication cart unlocked. RPN #121 stated that if they were in a resident's room they did not always lock the medication cart as they could see it from the resident's room. RPN #121 acknowledged that the medication cart was not within their view when they were in the resident's room.

In an interview, the Director of Care (DOC) stated they did not expect registered staff to lock the medication cart if they were in a resident's room administering medication as they would only be in the resident's room for a short time.

To leave the medication cart unlocked and unattended put residents at risk, as residents could access drugs within the unlocked medication cart.

Sources:
Observations of medication carts, "Medication Management" policy #RC-16-01-07 last updated December 2019, and interviews with RPN #121 and the DOC. [s. 130. 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 to ensure that all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a residents' right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

Inspector #522 observed a medication cart unattended and the electronic Medication Assessment Record (eMAR) screen was open and resident personal health information was visible.

Inspector #522 waited several minutes and noted the registered staff member was with a resident in their room and had their back to the door. A resident was noted walking with their walker in the hallway.

When Registered Practical Nurse (RPN) #121 came out of the resident's room they acknowledged they had left the eMAR open with resident names visible. RPN #121 stated they would normally lock the screen as it had resident names on it because of the Personal Health Information Protection Act.

In an interview, the Director of Care (DOC) stated they did not expect registered staff to lock the eMAR if they were in a resident's room administering medication as they would only be in the resident's room for a short time.

To leave the eMAR screen open and unattended posed a potential risk for a breech of resident's personal health information.

Sources:
Observations of medication carts and eMARs, "Medication Management" policy #RC-16-01-07 last updated December 2019, and interviews with RPN #121 and the DOC. [s. 3. (1) 11. iv.]

WN #9: 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:

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a Critical Incident System report was made in writing to the Director that it set out the long-term actions planned to correct the situation and to prevent the recurrence of falls for resident #012.

A Critical Incident System (CIS) report was submitted by the home to the Ministry of Long-Term Care on a specific date. The CIS report noted resident #012 had a fall with injury, there were no further amendments.

The CIS report noted the long-term actions planned to correct the situation and prevent recurrence were to follow the doctor’s instructions when the resident returned to the home.

When the resident returned to the home, the CIS report was not updated to include the long-term actions to prevent future falls.

In an interview, the Director of Care (DOC) stated they usually updated a CIS report about the condition of the resident upon return to the home and what interventions were in place.

The DOC reviewed the CIS report and acknowledged they did not update the CIS report regarding the long-term actions for falls prevention for resident #012 and should have.

Sources:
A CIS report and interview with the DOC. [s. 107. (4) 4. ii.]

Issued on this 27th day of April, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2021_725522_0003
Log No. / No de registre :	022773-20, 022791-20, 024918-20, 002360-21, 002381-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 22, 2021
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Southwood Lakes 1255 North Talbot Road, Windsor, ON, N9G-3A4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Ethier

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 Long-Term Care

Ministère des Soins de longue durée

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

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 # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2020_563670_0032, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 8. (1)(b).

Specifically;
A) The home will complete re-education with all registered staff members on a specific home area related to the home's policies and procedures included in the Falls Prevention and Management Program.
B) The home will complete re-education with Registered Practical Nurse #135 on the home's policies and procedures included in the Skin and Wound Program.
C) Keep documentation of the staff name and the date the staff member received the education.
D) Complete and document weekly audits of a minimum of three (if available) random residents who have had a fall. Audits will include monitoring to determine if Clinical Monitoring Records are completed, 72 hour post-fall monitoring is documented in the resident's progress notes, falls prevention measures are included in the resident's plan of care and are implemented, and if applicable, that the resident is reviewed by the interdisciplinary team/ Falls Committee for further follow-up.
E) Continue to complete and document weekly audits of a minimum of three (if available) random residents exhibiting impaired skin integrity, one of which should include a new or worsening skin condition. Audits will include monitoring to determine if weekly skin and wound assessments are being completed and that the impaired skin integrity has been added to the Treatment Administration Records with appropriate treatments ordered.
F) Audits shall be completed for 6 months or until compliance is achieved.
G) Keep documentation of corrective actions taken for any deficiencies found on the weekly audits.
H) The home will designate a Falls Program Lead(s) and this will be clearly communicated to all staff.
I) The Falls Committee will meet regularly to review and analyze resident falls, including resident #012.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's Skin and Wound Program: Wound Care Management" policy was complied with for resident #014 and #015.

O. Reg. 79/10 s. 48 (1) 2. States, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcer, and provide effective skin and wound care interventions."

Review of Extendicare's "Skin and Wound Program: Wound Care Management" policy noted in part that a resident exhibiting any form of altered skin integrity would receive specified care as set out in the plan of care and the resident's treatment regimen would be recorded on the electronic Medication Administration Record (eMAR) and/or electronic Treatment Administration Record (eTAR).

Review of the home's "Altered Skin Integrity Clinical Pathway" noted for altered skin integrity staff were to initiate a weekly Treatment Administration Record (TAR) for ongoing skin integrity assessments.

A) A skin assessment noted resident #014 had a new area of altered skin integrity. The assessment indicated a specific intervention for resident #014 to prevent further skin breakdown.

Review of resident #014's eTAR noted no documentation to assess the area of altered skin integrity weekly.

Review of resident #014's care plan noted a skin focus for the area of altered skin integrity had been created almost one month after the initial skin assessment. The intervention included in the initial skin assessment was not included in resident #014's care plan.

In an interview, Registered Practical Nurse (RPN) #130 acknowledged they created the skin focus in resident #014's care plan after the skin issue was resolved. RPN #130 acknowledged the care plan was to be updated when skin integrity issues were identified. RPN #130 stated they noticed the care plan was not completed when they did their skin and wound audit and entered the care plan at that time.

RPN #130 reviewed resident #014's eMAR/eTAR and acknowledged that there

was no documentation that the area of altered skin integrity was to be assessed weekly. RPN #130 stated all areas of altered skin integrity should be added to the eTAR for reassessment other than pressure ulcers as they were done by the skin and wound nurse.

B) Review of resident #015's progress notes noted resident #015 had an area of altered skin integrity.

A weekly impaired skin integrity assessment, which was locked just over two weeks after the area of altered skin integrity was identified and noted as completed, noted resident #015 had an area of altered skin integrity that was healed. The progress note auto populated by the skin assessment noted the assessment had been backdated.

There were no other skin and wound assessments of resident #015's altered skin integrity.

Review of resident #015's eTAR noted a treatment had not been created for weekly assessments of resident #015's area of altered skin integrity.

In an interview, RPN #130 acknowledged that the assessment was completed as a late entry. RPN #130 stated the assessment should have been completed on the day the area of altered skin integrity was noted and that it was likely when the weekly skin and wound audit was completed that the RPN was notified and inputted it as a late entry and had to entered 'healed' as the area had healed at that time.

RPN #130 reviewed resident #015's eMAR/eTAR and noted that weekly assessments of the area of altered skin integrity had not been entered and that it should have been entered when the area of altered skin integrity occurred.

The home's failure to follow their "Skin and Wound Program: Wound Care Management" policy placed resident #014 and #015 at risk of worsening skin integrity issues.

Sources:
Resident #014 and #015's clinical records, Extendicare's "Skin and Wound

Program: Wound Care Management" policy RC-23-01-02 last updated August 2019, the home's "Altered Skin Integrity Clinical Pathway" dated December 2020, the home's weekly impaired skin integrity audits, interviews with RPN #130 and the Director of Care. (522)

2. The licensee has failed to ensure that the home's "Falls Prevention and Management Program" policy was complied with.

O. Reg. 79/10 s. 48 (1) 1 states, "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: A falls prevention and management program to reduce the incidence of falls and the risk of injury."

Review of Extendicare's "Falls Prevention and Management Program" policy indicated for 72 hours post-fall, staff were to assess the resident at each shift and document the results of all assessments and actions taken during the 72 hour post-fall follow-up.

If a resident hit their head or was suspected of hitting their head (e.g. unwitnessed fall) a Clinical Pathway Monitoring was to be completed.

For 72 hours post-fall, staff were to assess the resident at each shift and document the results of all assessments and actions taken during the 72-hour post-fall follow-up.

Review of the home's "Clinical Monitoring Record" stated staff were to monitor resident's neurovital signs every hour x 4 hours then every 8 hours x 72 hours, if a head injury was suspected or the fall was unwitnessed.

Review of Extendicare's "Falling Star/Leaf Flagging Guide" noted the purpose of the Falling Star/Falling Leaf Program was to identify residents at risk for falls or falls injuries and clearly communicate to staff and other care team members' standard interventions for reducing risk. Residents would be identified by an icon on their bedroom door or near their bed.

A) Review of resident #008's post fall assessments noted the resident had four unwitnessed falls over three months.

i) Review of resident #008's Clinical Monitoring records for two falls, noted missing documentation. Registered Practical Nurse (RPN) #128 confirmed the missing documentation on each record and stated that staff were to document for the required time frames, unless a resident refused which should be documented.

Inspector #522 and the Director of Care (DOC) were unable to locate resident #008's Clinical Monitoring record for one of the other falls. The DOC stated a Clinical Monitoring record should be completed after every unwitnessed fall.

ii) Review of resident #008's progress notes noted the absence of 72 hour post-fall documentation on several shifts for two falls.

The DOC reviewed resident #008's progress notes and acknowledged the missing 72 hour post-fall documentation. The DOC stated post-fall monitoring should be documented in resident #008's progress notes each shift for 72 hours.

B) Review of resident #010's post-falls assessments noted resident #010 had four unwitnessed falls over a one month period.

i) Review of resident #010's Clinical Monitoring records for the four falls noted missing documentation.

Interviews with Registered Nurse (RN) #124 and Registered Practical Nurse (RPN) #128 confirmed the missing documentation on each record. RPN #128 stated staff were to document for the required time frames, unless a resident refused or the resident had another fall and a new Clinical Monitoring record was initiated, which should be documented.

ii) Resident #010 was observed in their room laying in bed. There was no falls logo observed in their room.

PSW #116 observed resident #010's room and acknowledged there was no falls logo at resident #010's bedside and there should be as resident #010 was a high falls risk.

iii) Review of resident #010's progress notes for 72 hour post-fall monitoring for one fall noted documentation missing on one shift.

The DOC reviewed resident #010's progress notes and acknowledged the missing 72 hour post-fall documentation. The DOC stated clinical monitoring should be completed in full for all unwitnessed falls and post-fall monitoring should be documented in resident #010's progress notes each shift for 72 hours. The DOC stated as part of falls prevention falling leaf signage should be posted above a resident's bed.

C) Resident #012 had numerous falls over a two month period.

i) A review of resident #012's progress notes noted the absence of documented 72 hour post-fall progress notes for two specific falls. A progress note was missing for one shift for three specific falls.

In an interview, RPN #125 stated they audited that post-falls assessments were completed but did not check that staff completed the 72 hours post-fall checks. RPN #125 stated staff would know to complete checks as it was on report to complete 72 hour post-fall monitoring. They stated they had spoken with staff as staff were only doing 72 hours post-fall checks for unwitnessed falls and 24 hour post-fall checks for witnessed falls.

ii) Review of resident #012's hard copy Clinical Monitoring records, noted seven unwitnessed falls that did not have a Clinical Monitoring record completed and six falls where the Clinical Monitoring record was not completed in full.

In an interview, RN #124 stated they were unable to locate resident #012's missing Clinical Monitoring records. RN #124 acknowledged all records should have the date on them and acknowledged records should be completed in full and they were not.

iii) Observation of resident #012's room noted no falls logo at resident #012's bedside. This was confirmed by RN #124 and Personal Support Worker #113.

The DOC reviewed resident #012's progress notes and acknowledged the missing 72 hour post-fall documentation. The DOC stated clinical monitoring

should be completed in full for all unwitnessed falls and post-fall monitoring should be documented in resident #012's progress notes each shift for 72 hours. The DOC stated as part of falls prevention falling leaf signage should be posted above a resident's bed.

The home's failure to follow their "Falls Prevention and Management Program" policy and "Clinical Monitoring Record "placed residents #008, #010 and #012 at risk as staff had the potential to miss post fall injuries if regular assessments were not completed. The home's failure to follow their "Falling Star/Leaf Flagging Guide" put residents #010 and #012 at risk as they were not flagged as a falls risk for staff who did not know them.

Sources:
Observations of resident #008, #010 and #012's rooms, resident #008, #010 and #012's clinical records, Extendicare's "Falls Prevention and Management Program" policy RC_15-01-01 last updated August 2019, Clinical Monitoring Record RC -15-01-01 A6 last updated August 2019 and Extendicare's Falling Star/Leaf Flagging Guide RC -15-01-01 A4 last updated August 2019, interviews with PSW #113, PSW #116, RN #124, RPN #120, RPN #123, RPN #125, RPN #130, and the DOC.

D) Review of Extendicare's "Falls Prevention and Management Program" noted in part that each home would designate one or more Falls Program Leads to act as clinical champions and coordinate key aspects of the program.

Extendicare's "Falling Star/Leaf Flagging Guide" noted in part that the Falls Program Lead would review the Falling Star/Leaf Program regularly (e.g. weekly) to ensure program identifiers were up-to-date, and conduct spot checks to ensure interventions were consistently and appropriately applied.

Review of Extendicare's "Post Fall Clinical Pathway" noted in part that after a resident fall registered staff were to refer to the interdisciplinary team members/and or Fall committee for further follow-up as needed.

In an interview, the DOC stated the Falls Program Lead used to be RPN #130 and now RPN #125 was helping. The DOC stated they should meet regularly to review and analyze falls along with the Clinical Care Coordinator (CCC), RPN

#130 and RPN #131. The DOC stated they were going to ask RPN #125 and RN #108 to attend also. The DOC stated they did not meet for a while due to COVID-19 and now they would get together.

The DOC stated they did not meet with the team to review the number of falls resident #012 had and interventions in place but believed RPN #130 and RPN #131 did. The DOC stated they did want to meet and involve the doctor prior to resident #012's care conference.

In an interview, the CCC stated there were no regular falls meetings, but they did look at falls at morning management meetings. The CCC stated that everyone was responsible for the falls program in the home and that the CCC, RPN #130, the DOC would be considered the leads of the program.

In interviews, RPN #125, RPN #130 and RPN #131 all stated they were not currently involved in the falls committee, other than RPN #125 who completed audits of post fall assessments to ensure they were completed properly. The RPNs stated since the pandemic there had not been a falls committee or meetings and they did not know who the Falls Program Lead was.

The RPNs and RN #108 stated they had not been involved in any interdisciplinary meetings regarding falls prevention for resident #012 who had numerous falls in a two month period.

Resident #012 was at risk for injury when the home did not follow their Falls Prevention and Management Program policies by having a clearly designated Falls Program Lead and an interdisciplinary or Falls Committee review of resident #012's numerous falls.

Sources:
Extendicare's "Falls Prevention and Management Program" RC_15-01-01 last updated August 2019, Extendicare's "Falling Star/Leaf Flagging Guide" RC -15-01-01 A4 last updated August 2019 and Extendicare's "Post Fall Clinical Pathway" RC-15-01-01-A5 last updated August 2019 and interviews with the DOC, CCC, RN #108, RPN #125, RPN #130 and RPN #131.

An order was made by taking the following factors into account:

Severity: Skin and wound assessments were not completed for resident #014 and #015 and an eTAR was not created to alert staff to complete the assessments. This placed resident #014 and #015 at actual risk for worsening skin integrity issues.
Clinical Monitoring records and 72 hours post-fall documentation were either missing or incomplete for residents #008, #010 and #012 after they had a fall. This put the residents at actual risk as staff had the potential to miss post fall injuries.
Resident #010 and #012 did not have a falls logo at their bedside which put them at actual risk as they were not flagged as a falls risk for staff who did not know them.

Scope: The scope of this non-compliance was widespread as the Skin and Wound Program policies were not followed for two of three residents and the Falls Prevention and Management Program policies were not followed for three of three residents reviewed during this inspection.

Compliance History: A compliance order (CO) is being re-issued for the licensee failing to comply with s. 8 (1) (b) of O. Reg 79/10. This subsection was issued as a CO on November 12, 2020, during inspection #2020_563670_0032 with a compliance due date of February 9, 2021. A CO was issued to a different section of the legislation on March 8, 2019, during inspection # 2019_674610_0010. (522)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 22, 2021

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

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

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 Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 22nd day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Julie Lampman

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