Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 5, 10, 12, 13, 20, 23, 2012	2012_043157_0001	Complaint Log #001866-11

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE GUILDWOOD
60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, the Clinical Coordinator, one Registered Nurse, two Registered Practical Nurses and the Physiotherapy Assistant.

During the course of the inspection, the inspector(s) reviewed the clinical health record of an identified resident, home policies related to falls and post fall analysis, email correspondence from family members of the resident.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. As a result of Fall Risk Assessments completed, an identified resident was assessed as being a high risk for falls and it was determined that the resident required a seat belt restraint in a wheelchair to prevent falls. The written plan of care does not provide clear direction to staff providing care to the resident [s.6(1)(c)]:
- The most current written plan of care does not identify the resident's need for a restraint in the wheelchair.
- The care plan incorrectly directs staff that the resident uses a walker and cane for mobility.
2. All staff involved in the care of this resident did not collaborate with each other in the assessment of the resident to ensure that they are consistent with and complement each other [s.6.(4)(a)(b)]:
- Physiotherapy assessments completed in response to a referral from nursing staff state the resident has not had any falls and assessments do not establish care goals and objectives consistent with or complementing nursing activities.
"Physiotherapy Reassessment/Progress Notes/Discharge Note" completed in April, 2011 - Objective not completed, States "Falls: None" when the resident had experienced 5 falls in the months of March and April.
"Physiotherapy Reassessment/Progress Notes/Discharge Note" completed in July, 2011 - Objective not completed, States "Falls: None" when the resident had experienced 6 falls in the months of May - July.
Physiotherapy assessments in April and July do not identify a treatment objective.

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 resident written plans of care provide clear direction to staff providing direct care to the resident and to ensure that the assessments all staff involved in different aspects of care for a resident are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following subsections:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. In August, 2011 an email complaint related to several care issues was received by the Administrator from a family member of a resident. The complaint was not forwarded to the Director.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following subsections:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. Clinical progress notes indicate that an identified resident had falls on 14 dates dates in 2011. A post fall assessment using a clinically appropriate assessment instrument was not completed for any of the documented falls.
The facility policy for "Post Fall Analysis" (Policy # 09-02-02, September 2010) requires:
- "If the resident is high or medium risk for falls, Registered Staff will determine how many falls the resident has had in the current quarter. If this is the first fall for the quarter the Registered Staff will initiate the Post Fall analysis form."
-"The members of the interdisciplinary team will work together to complete the Post Fall Analysis form within 48 hours of the fall including revising and updating the resident's fall care plan with interventions that address the risk factors identified within the Post Fall Analysis form."
This policy was not complied with as there is no evidence of a Post Falls Analysis being completed for any of this resident's falls.
2. Quarterly assessments for an identified resident assessments completed in January, 2011 and April, 2011, both indicate that the resident had a fall in the past 31 to 180 days. The section "Information on most recent fall" is marked NA on both assessments despite the fact that the resident had a number of falls. Both assessments indicate "No objective specified" for care planning.

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 when a resident has fallen, the resident is assessed and a post fall assessment is conducted using a clinically appropriate assessment instrument, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.
2. An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or the safety, security or well-being of residents for a period greater than six hours.
3. A missing or unaccounted for controlled substance.
4. An injury in respect of which a person is taken to hospital.
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Progress notes in an identified resident's clinical health record indicate the following:
- In July, 2011, the resident was found to have an injury. The resident was transferred to hospital for treatment. A Critical Incident Report not submitted to the Director.
- In August, 2011 an identified resident was transferred to hospital for investigation and treatment of an injury. A Critical Incident Report was not submitted to the Director.

Issued on this 23rd day of January, 2012

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