Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 5, 2014	2014_293554_0002	O-000918-13	Complaint

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

KELLY BURNS (554), MARIA FRANCIS-ALLEN (552)

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): January 08 - 09, 2014

Two Complaint Inspections were completed concurrently (#000252-13 and #000918-13).

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Clinical Care Coordinator(CC), Physiotherapist(PT), Registered Staff, Personal Support Worker(PSW), Housekeeping Staff, RAI Coordinator, and Family or Visitor.

During the course of the inspection, the inspector(s) Toured the home, reviewed health records, complaint log binder (including quarterly trending and analysis), critical incident binder, staffing assignments, reviewed the home's policies relating to Falls Prevention and Management, Post Falls Assessment and Complaints.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

s. 6. (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).

Findings/Faits saillants :

1. Related to Log #000252 - Resident #002

The Licensee failed to ensure that there was a written plan of care for Resident #002 that set out clear direction to staff and others who provided direct care to the resident.

1) A clinical record review conducted for a specific period, indicated Resident #002 sustained eight (8) falls during this time frame .

The PSW(#105) who was assigned to Resident #002 the evening specifically identified, indicated "no awareness of resident being at risk for falls".

The written care plan, for Resident #002, for this time period, failed to identify a focus of falls risk or falls prevention and interventions to reduce or mitigate risk until an amendment was made on a later date.

2) Clinical Records, for Resident #002, indicated that a falls risk assessment using the MORSE Falls Risk Assessment or the home's computerized Falls Risk Assessment tool, was not conducted until later that month. The outcome of this assessment indicated that Resident #002 was a high risk for falls.

The CC, RAI Coordinator and DOC indicated that according to the home's policy, "a Falls Risk Assessment should have been completed by registered nursing staff at the time of each fall".

3)Progress Notes reviewed indicated:
- that on a specific date, Resident #002 had fallen and was unable to weight bear due to injuries sustained from a fall.
- for the period reviewed the resident's care needs changed from independent-minimal care to requiring extensive assistance for all ADL's, requiring the use of a mechanical lift for transfers and the use of mobility aides.
- the resident was transferred to hospital on a specific date for investigation of injuries and returned to the long term care home.

The plan of care for Resident #002 was not revised to reflect changes in resident's care needs until a later date.

4)Weekly Falls Prevention Meeting Minutes for the period reviewed, indicated the following related to Resident #002:
- walker to be provided, encourage use - this direction was not provided in the resident's plan of care.
- resident not to weight bear for a few days due to severe pain and to call for assistance - this direction was not provided in the resident's plan of care until the plan was revised until a later date.

Weekly Falls Prevention Minutes for the second period reviewed indicated the following related to Resident #002:
- close monitoring by charge nurse; 'every 30 min checks for safety during periods where risk for falls is increased. Resident will attempt to get up from bed'. This direction was not placed on care plan until a later date.

Progress notes indicate that a falls mat was placed at the resident's bedside following a fall on the night shift - this direction was not provided on the plan of care until a later date. [s. 6. (1) (c)]

2. Related to Log #000252 - Resident #002

The Licensee failed to ensure that Resident #002's substitute decision-maker, and any other persons designated by the resident were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A clinical record review, for the period reviewed, identified that Resident #002

sustained eight falls during this time period.

Progress notes, and resident incident reports indicate that the Substitute Decision Maker (SDM) or other persons designated by the resident were not notified of all the falls that Resident #002 had experienced.

The Director of Care stated that "registered nursing staff had not notified the resident's SDM that the resident had experienced falls on the above dates". The DOC indicated that it is the "home's expectation and practice for registered nursing staff to notify the resident's SDM within 24 hours of a fall occurring". [s. 6. (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 the resident's substitute decision-maker, and any other persons designated by the resident are given an opportunity to participate fully in the development and implementation of the resident's plan of care. The Licensee will ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Related to Log #000252 - Resident #002

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

Review of the home's policy #RESI-10-02-01 -'Falls Prevention and Management Program' directs the following:
- a flagging system will be used to clearly identify residents that are at high risk for falls (e.g. Falling Leaf).
- when a resident falls, registered nursing staff will immediately assess the resident, complete an incident report, and initiate the 'high risk' flagging system
- registered nursing staff are to complete ongoing assessments each shift x 72 hours and document the assessment in the progress notes
- complete post falls assessment and update the care plan
- communicate changes in plan of care to staff

The Licensee did not comply with the established policy by failing to:
- completed a Falls Risk Assessment
- resident care plan was not amended until a later date, to indicate a focus of falls risk or interventions to reduce falls or to mitigate risk
- to complete resident incident reports or post-fall assessments following each fall experienced by this resident
- document assessment and health status of resident #002 each shift x 72 hours.

The PSW(#105) who was assigned to resident #002 the evening specified, was not aware of resident being at risk for falls.

Personal Support Worker's(#109, 112, and 105), and a Housekeeping staff(#108) indicated that they were not aware of a 'flagging system' used by the home.

The Administrator and DOC stated that "they were not surprised that staff did not know that the falling leaf symbol was used to identify residents at 'high risk' for falls, as many changes had occurred with the Falls Prevention Program and it was difficult for staff to keep current as a result of numerous changes".

The DOC and CC indicated that "the registered nursing staff are to complete an initial assessment of a resident who has fallen, to complete an incident report, are to assess resident who has fallen each shift x 72 hours, are to complete a post-falls assessment,

notify resident's SDM of a resident who has experienced a fall and to update resident's care plan to identify a focus of 'falls risk' and to identify goals and interventions to prevent re-occurrences" of a similar nature.

DOC stated awareness that "registered nursing staff were not consistently completing the required the documentation and assessments following a resident's fall". [s. 8. (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 where the Act or 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 related to Falls Prevention and Management, the Licensee is required to ensure that the plan, policy, protocol, procedure strategy or system, is complied with, to be implemented voluntarily.

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:

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. Related to Log # 000252 - Resident #002

The Licensee failed to 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 this is specifically designed for falls.

A clinical record review conducted for a specific period, indicated Resident #002 sustained eight (8) falls during this time frame .

Resident #002 did not have a Falls Risk Assessment completed until a later date, despite having experienced eight falls during the period reviewed.

The home's policy, 'Falls Prevention and Management Program' directs the following:
- each resident admitted to the home will be assessed for falls risk, using the MORSE risk assessment
- registered nursing staff are to complete a MORSE falls risk assessment on admission, when there is a significant change in the resident's health status (e.g. falls) or when newly triggered in MDS

The Licensee failed to identify Resident #002 as being at risk for falls and failed to put into place interventions to reduce falls or to mitigate risk related to falls. [s. 49. (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 the Licensee 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. Related to log # 000918 - Resident #001

The Licensee failed to ensure that every written complaint made to the licensee or a staff member concerning the care of a Resident #001
was investigated, resolved where possible, and a response provided within 10 business days.

The Administrator confirmed that written letter's of complaint were received by the licensee regarding care concerns for Resident #001 related to medication administration and the resident's right to communicate in confidence with any person without interference.

Interview of the Administrator and the DOC indicated a response was not provided to the complainant and there was no documented evidence that an investigation was completed. [s. 101. (1) 1.]

2. Related to Log # 000252 - Resident #002

The Licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident is investigated, resolved where possible, and a response provided within 10 business days. Where the complaint alleges harm or risk of harm to one or more residents, the licensee has the investigation commenced immediately.

The Administrator and DOC confirmed that a verbal complaint was received by the licensee, regarding concerns that Resident #002, had fallen and was left lying on the ground for an extended period of time; the complainant further indicated that the resident was not assessed by a 'nurse'.

The Administrator and the DOC, stated that "staff interviews regarding the allegation were not conducted immediately".

The Administrator and DOC stated that "no response was provided either verbally or in writing to the complainant". [s. 101. (1) 1.]

3. Related to Log #000918 - Resident #001

The Licensee failed to ensure that a documented record is kept in the home that includes: the nature of each written complaint, the date of the complaint and the type of action taken to resolve the complaint.

As demonstrated by:

Review of the home's complaint log book for a specific time period indicated that none of the three complaint letters received by the licensee pertaining to Resident #001 were documented in the complaints log. [s. 101. (2)]

4. Related to Log # 000252 - Resident #002

The Licensee failed to ensure that a documented record is kept in the home that includes: the type of action taken to resolve the complaint and final resolution to the complaint.

As demonstrated by:

A review of the home's Complaints Log binder for a specific time period indicated that the complaint, in relation to the incident involving Resident #002, was not documented in the complaints log and that there was no indication as to a response or final resolution provided to the complainant. [s. 101. (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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or the operation of the home:
- has been investigated, resolved where possible, and response provided within 10 business days of the receipt of the complaint, and
- where the complaint alleges harm or risk of harm to one or more residents, has the investigation commenced immediately.

The Licensee will ensure that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including: the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

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

Findings/Faits saillants :

1. Related to Log # 000252 - Resident #002

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was
applied. [s. 107. (3.1)]

The licensee failed to ensure that an injury of person that resulted in transfer to hospital was reported within one business day to the Director.

A review of Resident #002's progress notes from the time period identified, indicated:
- Resident #002, sustained a fall, resulting injury. Within an hour of the resident falling, staff reported that the resident was unable to weight bear. Assessment was completed by the Physiotherapist, who recommended x-rays to rule out a fracture. Family were contacted and agreed to transfer resident to hospital for further assessment. Resident was transferred to hospital.

The Administrator and DOC, both indicated that the Critical Incident Report has never been submitted for Resident #002. [s. 107. (3.1)]

2. Related to Log #000252 - Resident #002

It is noted, that O.Reg 79/10, s.107(3) was amended as of September 15, 2013. This finding relates to an incident that occurred prior to September 15, 2013 and therefore the previous s.107 (3) was
applied. [s. 107. (3.1)]

The Licensee failed to make a report in writing to the Director, of an incident described in O.Reg 79/10, s.107 (3), within 10 days of becoming aware of the incident, that includes: description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

The Administrator and DOC indicated that no reports in writing were or have been provided to the Director, pertaining to Resident #002, for the period identified. [s. 107. (4) 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 the Director is informed of incidents in the home, required under O.Reg 79/10, s.107(3), no later than one business day after the occurrence of the incident, followed by the reports required under subsection (4);, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Related to Log #000252 - Resident #002

Under O.Reg. 79/10, s.219 (1) the intervals for the purpose of subsection 76(4) of the Act are annual intervals.

The Licensee failed to ensure that all direct care staff have been provided annual training in falls prevention and management.

Interview of PSW's (#109, and #112), and a Housekeeping staff (#108) could not remember if they had training in 2013 relating to Falls Prevention and Management. The PSW's (#109 and #112) and housekeeping staff could not identify how they would know if a resident was 'high risk for falls'.

DOC stated "that there were no staff training records relating to Falls Prevention and Management for 2013". [s. 221. (1) 1.]

Issued on this 6th day of February, 2014

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