Ontario

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 15, 2016	2016_321501_0022	032803-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

SUSAN SEMEREDY (501), GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 25, 28 and 29, 2016.

During this inspection the following intakes were also inspected:
Intake #0086887-14 related to discharge of a resident and
Intake #027105-16 related to pain management.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager, Minimum Data Set/Resident Assessment Instrument (MDS/RAI) Co-ordinator, Resident Program Manager, Support Services Manager, Social Worker, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Family Council President, Resident Council President, Community Care Access Centre (CCAC) Co-ordinator, CCAC Patient Relations Officer, residents and substitute decision makers (SDMs).

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2015_360111_0001	501
O.Reg 79/10 s. 90. (1)	CO #001	2015_360111_0001	600

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. (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 2007, c. 8, s. 6 (4).
(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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

A complaint inspection was conducted during the Resident Quality Inspection for log #008687-14 and was related to an intake that was initiated on an identified date.

An interview with the complainant alleged resident #020 was discharged early from the Convalescent Care (CC) Program. He/she also alleged that the physiotherapist deemed resident #020 as independent with a walker however, according to the complainant the resident was not independent with a walker. An interview with the resident's spouse confirmed the resident was not able to safely transfer and nearly fell while returning home.

A record review revealed the resident's long term goals at the end of the 90 day CC program was to be able to independently walk indoors using a walker, with good balance and posture. The planned discharge from the CC program was noted to be on an identified date, which reflected the end of the 90 day program. However, during an

interview with the complainant and resident #020's spouse, it was revealed that the family chose to take him/her home on an identified date, three days earlier than the planned discharge date.

Record review related to resident #020's function revealed a discrepancy between the physician and physiotherapist. The physiotherapist's assessment on an identified date indicated that he/she partially achieved the goals noted above. The physician's documentation in the progress notes on an identified date, revealed that resident #020 was able to independently transfer and should be able to manage at home.

An interview with the physician revealed his/her documentation was based on a report provided by the physiotherapist during a discharge meeting that was held on an identified date. The physician confirmed that there was a discrepancy between the reported function of resident #020 but could not further explain the reason for this. The physiotherapist no longer worked at the home and was not available for an interview.

An interview with RN #100 who is in charge of the CC program revealed that residents are discharged at the end of 90 days regardless of their function. RN #100 also confirmed that despite resident #020 being deemed a two person transfer with a walker by the physiotherapist on an identified date, the resident would be discharged home at the end of the 90 day program.

An interview with the Community Care Access Centre (CCAC) Co-ordinator revealed that when a resident is unable to meet the discharge goals and can potentially make further functional gains, that it is the physiotherapist's responsibility to refer residents to a rehabilitation center. Documentation to support that resident #020 was referred to such a centre was not noted during the review of the medical record.

An interview with a CCAC Patient Relations Officer revealed that the service plan for discharge was made according to resident #020's reported function at a discharge meeting held on an identified date. Resident #020's function was reported as, transferring independently and he/she was able to walk short distances with a walker.

Due to the discrepancies reported by the above staff members regarding resident #020's assessments as well as an unclear communication with the placement co-ordinator, the resident was discharged home and was unable to safely transfer. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments

were integrated and are consistent with and complemented each other. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change.

An interview with resident #005’s substitute decision maker (SDM) revealed the resident had complained to the SDM about staff applying incontinent products on him/her during the day. The SDM further indicated the resident was continent and was able to inform the staff when he/she needed to use a toilet. The SDM had communicated resident #005’s displeasure to the home.

Review of resident #005’s Minimum Data Set (MDS) assessment dated October 19, 2016, indicated the resident was continent of bladder and incontinent of bowels. Resident wore a brief.

Review of the personal support worker (PSW) documentation for identified months indicated the resident had been continent of bowels during the days and had an identified amount of episodes of incontinence at nights during the observation period.

Interview with PSW #107 who was providing care to resident #005 during the day shift, revealed the resident had been assessed to be continent of bladder and continent of bowels as he/she was able to inform the staff when he/she needed to use a toilet. Further the PSW confirmed the resident had been wearing an incontinent product at all times since admission in the home.

An interview with registered nurse (RN) #114 revealed resident #005 was incontinent when he/she was admitted in the home. After the first quarter and after the physician had adjusted medications, his/her condition improved. The resident was able to ask for assistance when he/she needed to use the toilet during days and he/she should not wear an incontinent product. The RN confirmed the written plan of care did not reflect the resident's current care needs.

An interview with the resident assessment instrument (RAI) co-ordinator #116 indicated the registered staff completed the continence assessment when the resident’s condition had changed, however he/she also confirmed the resident should be assessed for use of incontinent products and the resident’s plan of care should reflect resident #005’s current care needs.

An Interview with the DOC confirmed that when the resident's care needs changed, the resident's plan of care should reflect those changes. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care was based on an assessment of the resident and the resident's needs and preferences, to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and to ensure that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

An observation during medication administration on an identified date, revealed registered practical nurse (RPN) #115 crushed, mixed with apple sauce, and administered medications to resident #030.

A review of the resident's plan of care revealed the resident was on a regular diet. A review of the physician order failed to reveal that resident #030 had a swallowing problem and his/her medication was to be administered crushed. A review of the medication administration record (MAR) failed to reveal an alert for the medications to be crushed.

An interview with physician #117 indicated he/she was not aware why resident #030 received crushed medication. He/she also revealed the practice in the home was if some resident has difficulty swallowing, the nurse will notify the physician and the pharmacy. The physician will complete the order for medication to be crushed and the pharmacy will review the medication to confirm if those medications can be crushed and post an alert on the MAR to "crush med".

An interview with RPN #115 revealed that he/she had crushed the medication for resident #030 because the resident preferred to take the medication crushed with apple sauce instead of whole pills. The resident did not have swallowing problems. Further the RPN revealed the resident found the medications to be distasteful when he/she took whole pills. The RPN also confirmed that resident #030's preference had not been communicated to the physician and the pharmacy.

Interview with DOC confirmed the registered staff did not follow the physician order giving the medication crushed before it was communicated to the physician and the pharmacy. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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:
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to fully respect and promote residents' right to have his or her lifestyle and choices respected.

An interview with resident #001 during stage one of the Resident Quality Inspection (RQI) revealed that he/she does not get to choose when he/she has a shower. The resident stated he/she does not like to have a shower at a certain time of day because he/she does not feel comfortable afterwards. An interview with resident #001's SDM revealed the resident does not like to have showers and he/she is aware of this. The SDM indicated that a different time for resident #001 to have a shower would be what he/she is accustomed to.

Record review revealed there was no interdisciplinary care conference (IDCC) record for the past year for resident #001.

An interview with PSW #110 revealed he/she was aware that resident #001 does not like to be showered. PSW #110 revealed he/she has informed RPN #113 of resident #001's dislike of showers. Interview with RPN #113 revealed he/she has not considered offering a shower at another time of day because resident #001 is in an identified bed and these residents all have showers during a certain time of day. RPN #113 further indicated that changing a resident's shower time would mean the PSWs routines would have to change.

An interview with the DOC revealed that the home could accommodate resident #001's choice to have a shower during his/her preferred time. The DOC indicated that during IDCC meetings residents and SDMs are asked if they have any concerns regarding care. Both the DOC and Administrator could not confirm whether showers and lifestyle choices were a topic for discussion during these care conferences. [s. 3. (1) 19.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a record is kept of the date, the participants and the results of the interdisciplinary care conferences.

Record review revealed that there was no record of interdisciplinary care conferences for residents #001, #003 and #005 for the past year that included the participants and the results of the conferences. An interview with the DOC revealed these conferences did take place however, he/she confirmed there was no record that documented these conferences because the home had switched to using an electronic version and staff needed more education to ensure the conferences are recorded using this new format. [s. 27. (1) (c)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council

Specifically failed to comply with the following:

s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).

Findings/Faits saillants :

1. The licensee had failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations.

An nterview with the Family Council President revealed that he/she has never seen a written response from the home regarding any concerns or recommendations. Review of the Family Council meeting minutes revealed that there was a Family Council Action Sheet that was received by the home July 11, 2016, with four items of concerns. Further review of the minutes revealed there was no written response to these concerns. The concerns were not addressed until a meeting on November 4, 2016, when the Administrator was in attendance. An interview with the Administrator revealed the home usually meets with the Family Council to discuss their concerns and have not formerly responded to them in writing within 10 days. [s. 60. (2)]

Issued on this 16th day of December, 2016

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

Original report signed by the inspector.