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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jan 30, 2015	2014_251512_0022	T-127-14	Resident Quality Inspection

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

TILDA HUI (512), JOANNE ZAHUR (589), NICOLE RANGER (189), SOFIA DASILVA (567)

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): December 2, 3, 4, 5, 8, 9, 10, 11, 12, and 15, 2014.

Additional inspections related to the following log #s were also completed during this inspection:
1) T-789-13, critical incident,
2) T-1069-14, critical incident,
3) O-428-14, follow-up order.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care (DOC), associate director of care (ADOC), registered nurse (RN), registered practical nurse (RPN), clinical care coordinator (CCC), food services manager (FSM), environmental services manager (ESM), registered dietitian (RD), personal support worker (PSW), activation staff, dietary aide (DA), housekeeping aide, residents, family members and substitute decision makers.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

16 WN(s)
6 VPC(s)
1 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
O.Reg 79/10 s. 117.	CO #001	2014_328571_0001	512

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 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.

1. Record review for resident #009 revealed that medication prescribed for the resident was not administered in accordance with the directions for use specified by the prescriber. The resident's daily medication administration times for an identified medication A are 8:00 a.m. and 12:00 p.m. On the following occasions, medication A was recorded to be administered as follows:

-On December 10, 2014, the 8.a.m. scheduled administration was administered at 10:43 a.m. and the 12:00 p.m. was administered at 2:13 p.m.
-On December 7, 2014, the 12 p.m. scheduled administration was administered at 2:04 p.m.
-On December 6, 2014, the 8.a.m. scheduled administration was administered at 10:20 a.m. and the 12:00 p.m. was administered at 1:56 p.m.

2. Record review for resident #008 revealed that medication A is to be administered daily to the resident at 6 a.m., 10 a.m., 2 p.m., and 6 p.m. Review of the electronic medication administration record (eMar) revealed that medication A was administered at the following times, on the dates indicated:

-On December 10, 2014, the 6 p.m. scheduled administration was administered at 8:11 p.m.
-On December 4, 2014, the 10 a.m. scheduled administration was administered at 11:17 a.m.
-On November 30, 2014, 6.p.m. scheduled administration was administered at 9:42 a.m.

3. Record review for resident #001 revealed that medication A is to be administered to the resident at 8 a.m., 12 a.m., and 5 p.m. Review of the eMar revealed that medication A was administered at the following times, on the dates indicated:

-On December 11, 2014, the 8 a.m. scheduled administration was administered at 9:46 a.m.
-On December 9, 2014, the 8 a.m. scheduled administration was administered at 9:40 a.m.
-On December 7, 2014, the 8 a.m. scheduled administration was administered at 9:07 a.m.

Medication A contains an identified pharmaceutical ingredient which is commonly used to treat the symptoms of an identified group of neuro-musclular diseases with symptoms

such as shakiness, stiffness, and difficulty moving. This identified disease is thought to be caused by too little of a naturally occurring substance in the brain. The identified pharmaceutical ingredient changes into this naturally occurring substance in the brain, helping to control movement. This medication is taken by mouth, usually 3 to 4 times a day or as directed by the doctor. This medication should be taken regularly to get the most benefit from it, and should be taken at the same times each day. Since a decrease in the effectiveness of this medication just before the next dose may be experienced in some populations, it is important to take it at the scheduled time.

4. Record review for resident #001 revealed that an identified medication B is to be administered to the resident daily at 8 a.m. Review of the eMar revealed that medication B was administered at the following times, on the dates indicated:

-On December 9, 2014, medication was administered at 10:23 a.m.
-On December 7, 2014, medication was administered at 10:27 a.m.
-On December 5, 2014, medication was administered at 9:42 a.m.

Medication B is one of the antiepileptic medications used to prevent epileptic seizures. It belongs to a class of medications called benzodiazepines, which act on the brain and nerves of the central nervous system to produce a calming effect. To get the most benefit from the medication, it should be taken consistently with the right dose at the right time. This medication may cause withdrawal reactions, especially if it has been used regularly for a long time or in high doses. In such cases, withdrawal symptoms such as headaches, trouble sleeping, restlessness, hallucinations/confusion, nausea, and seizures may occur if this medication is suddenly stopped.

5. Record review for resident #001 revealed that an identified medication C was to be administered to the resident daily at 8 a.m. Review of the eMar revealed that medication C was administered at the following times, on the dates indicated:

-On December 4, 2014, scheduled medication was administered at 11:11 a.m.
-On December 3, 2014, scheduled medication was administered at 11:09 a.m.
-On December 2, 2014, scheduled medication was administered at 11:01 a.m.

Medication C is an identified mineral supplement used to treat an identified medical condition. The mineral is best absorbed when taken on an empty stomach before or 2 hours after meals. It is important to take medication C exactly as prescribed or recommended by the doctor to keep up the level of effectiveness.

Interviews with the clinical care coordinator and the DOC confirmed that the above mentioned medications for the residents were not administered as specified by the prescribers, posing potential serious health risks to the residents for not administering the medications at the scheduled times. [s. 131. (2)]

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. 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. (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. Record review of resident #006 noted the resident had a stage one pressure ulcer identified on his/her coccyx during two identified time periods. The resident was also identified to have a stage four pressure ulcer on his/her right iliac crest on an identified date. Review of the resident's current and past care plans revealed no interventions developed to address the pressure ulcers on the resident's coccyx and right iliac crest.

Interviews with an identified RN and the ADOC confirmed that there were no interventions developed to address the issue of the altered skin integrity and therefore did not set out clear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

2. Review of the care plan with an identified date for resident #003 indicated that the resident was described as being continent of bowel and occasionally incontinent of bladder. However, review of the resident's minimum data set assessment (MDS) dated in the same month, described the resident as occasionally to frequently incontinent of bowel and frequently incontinent of bladder.

Interview with the ADOC confirmed that this was conflicting information on the resident's continence level descriptions and set out unclear directions to staff and others who provide direct care to the resident. [s. 6. (1) (c)]

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

Record review indicated that resident #003 was described as frequently incontinent of bladder and occasionally incontinent of bowel in the resident's plan of care.

Interview with two identified PSWs revealed the resident was continent for both bladder and bowel during day and evening and could go to the bathroom by him/herself at night. The resident uses incontinent briefs for protection and does not need assistance except with cleaning up after bowel movement. Interview with an identified RPN revealed that the resident was frequently incontinent of bladder and occasional incontinent of bowel. The RPN referred to the care plan before he/she provided the responses as he/she was not sure what the continence status of the resident was. [s. 6. (4) (a)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan of care is no longer necessary.

Observations made on December 8 and 9, 2014, and interview with an identified PSW revealed that resident #008 was up in his/her wheelchair for breakfast and lunch and, transferred to bed after lunch daily.

Review of the resident's plan of care did not indicate that she/he was up for breakfast and lunch and, transferred to bed after lunch daily.

Interview with an identified registered nursing staff confirmed that the above mentioned information was not indicated in the resident's plan of care. The registered nursing staff also confirmed that the resident's plan of care was revised on December 11, 2014, however the information to indicate that the resident is up for breakfast and lunch, and then transferred to bed after lunch daily was not reflected in the revised plan of care [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 that the plan of care set out clear directions to staff and others who provide direct care to the resident, and to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: 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 that residents are protected from abuse by anyone in the home.

Record review indicated that on an identified date at an identified time, resident #031 entered the room of resident #003 and displayed abusive sexual behaviours towards resident #003. Resident #031 believed resident #003 to be his/her spouse who had passed away recently. Resident #031 was removed from the scene and returned to his/her own room after much encouragement, and the resident was hitting staff. Resident #031 was monitored more frequently than the regular hourly check. This incident was the first inappropriate sexual behaviour exhibited by resident #031.

Interview with the administrator confirmed that the incident did take place and the home did not protect resident #003 from abuse. [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 that residents are protected from abuse by anyone in the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately reports the suspicion and the information upon which it was based to the Director.

Record review revealed that on an identified date at an identified time, resident #031 entered the room of resident #003 and displayed abusive sexual behaviours towards resident #003. Resident #031 believed resident #003 to be his/her spouse who had passed away recently. Resident #031 was removed from the scene and returned to his/her own room after much encouragement, and resident was hitting staff. Resident #031 was monitored more frequently than the regular hourly check. A critical incident report was submitted by the home under "Other Critical Incident" 20 hours after the incident occurred. There were no after-hours pager calls or other notifications to the Director immediately after the incident occurred.

Interview with the administrator confirmed that the incident was not reported to the Director immediately by using after-hours pager calls or other notifications. [s. 24. (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 home had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #5: 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. The licensee has 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 that is specifically designed for falls.

Record review for resident #009 revealed that the resident had a fall on an identified date in 2014. The resident had slid to the floor from his/her wheelchair. There was no evidence of a post-fall assessment using an appropriate assessment instrument.

Interview with an identified registered nursing staff confirmed that a post-fall assessment using an appropriate assessment instrument was not conducted for resident #009. [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 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 that is specifically designed for falls, 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 has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review noted that resident #006 had a stage one pressure ulcer on his/her coccyx during two identified periods in 2014. There was no evidence of any weekly skin and wound assessment being completed for the resident during these two periods.

Interview with an identified RN confirmed that weekly skin and wound assessments were not conducted for the stage one pressure ulcer during the above mentioned periods. Interview with the ADOC confirmed that the weekly assessments should have been completed. [s. 50. (2) (b) (iv)]

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 exhibiting altered skin integrity, including skin breakdown and pressure ulcers has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that, 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 contacts 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 a resident's health condition or remains unable to determine whether the injury has resulted in a significant change in the resident's health condition, the licensee informs the Director of the incident no later than three business days after the occurrence of the incident, and follows with the report required under subsection (4).

Record review of resident #021 revealed that the resident suffered a fall on an identified date. A review of the progress note entry indicated that the resident had rolled out of his/her bed. The resident was transferred to hospital on the same day, and was diagnosed with a hip fracture. The resident expired three days later and the home submitted a critical incident report to the Director on the fourth day of the fall incident.

Record review revealed that on the third day after the resident was transferred to the hospital, the home called the hospital to learn of the resident's status. A review of the home's internal investigation records as well as interviews with the clinical care coordinator, the DOC and the administrator confirmed that the home was aware of the resident's hip fracture and significant change in the resident's health condition. On the day after the expiry of the resident, one of the resident's family called the home to inform them of the resident's passing. The home did not inform the Director of the incident no later than three business days after the occurrence of the incident as required under subsection (4). [s. 107. (3.1) (a)]

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 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, 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 a resident's health condition or remains unable to determine 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), to be implemented voluntarily.

WN #8: 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 responsive behaviours policy is complied with.

Review of the home's policy titled Responsive Behaviours with policy number 09-05-01 and date of origin September 2010, stated that a resident with responsive behaviours whose behaviours place the resident or others at risk of harm is to be referred to the local community psychogeriatric resource for further assessment and care planning intervention suggestions.

Record review revealed that on an identified date and at an identified time, resident #031 entered the room of resident #003 and displayed abusive sexual behaviours towards resident #003. Resident #031 believed resident #003 to be his/her spouse who had passed away recently. Resident #031 was removed from the scene and returned to his/her own room after much encouragement, and resident was hitting staff. Resident #031 was monitored more frequently than the regular hourly check. Record review did not reveal any referral made for resident #031 after the incident to local community psychogeriatric resources including the Behavioral Support Ontario (BSO) and psycho-geriatric assessment centre at Ontario Shores, for further assessment and care planning intervention suggestions.

Interview with an identified registered nursing staff indicated that he/she believed the resident's behaviour was not serious enough to be referred to these community resources. Interview with the administrator confirmed that a referral should have been made to these organizations to ensure that resident #031 received further assessment and care planning intervention suggestions. [s. 8. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On December 2, 2014, the door to the soiled utility room was observed to be unlocked, and the dirty linen storage room was found to be unlocked also.

Interview with the registered staff confirmed that the storage rooms should be locked while unsupervised by staff. [s. 9. (1) 2.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily accessed and used by residents at all times.

Observation made on December 12, 2014, at 3:30 p.m. in the room of resident #008 identified the resident in bed in a supine position. The resident's call bell was observed tied to the wire bar on the bedside cabinet next to the resident's bed. The cabinet was placed about one feet away from the resident's bed and was behind the level of the resident's shoulder in bed. The cord of the call bell was dangling down towards the floor. The inspector asked the resident to demonstrate how he/she could use the call bell. The resident was not able to reach the call bell cord and activate the call bell.

Interview with an identified PSW stated that he/she just came on evening shift and it was the day staff who had put the resident in bed. The PSW confirmed that the resident would not be able to activate the call bell at the current location. The PSW brought the call bell up to the bed and secured the cord next to the resident's left hand. [s. 17. (1) (a)]

2. Observation made on December 12, 2014, at 3:25 p.m. in the room of resident #031 identified the resident in bed on top of the bed cover, in a supine position and with outside shoes on. The call bell cord was lying on the floor next to the bedside cabinet about one and a half feet from the bed. The resident was not able to reach the call bell to activate the button.

Interview with an identified PSW confirmed that the call bell was out of reach for the resident. The PSW placed the cord back on the bed beside the resident to be within reach. [s. 17. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

Interviews with an identified PSW and registered staff revealed that resident #012 can independently change into her/his pyjamas and go to bed early, but will also get up many times throughout the evening until he/she settles at approximately 9:30 to 10:00 pm.

Record review failed to reveal the above mentioned nightly pattern for the resident.

Interview with the DOC confirmed that resident #012's plan of care was not reflective of his/her sleep patterns and preferences. [s. 26. (3) 21.]

2. Resident #012s interview revealed that staff tell him/her to go to bed at 8:00 pm and, he/she prefers to stay up until 9:30 to 10:00 pm. Resident #012 perceives that his/her preference to stay up later is not being respected. [s. 26. (3) 21.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is incontinent received an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence where the condition or circumstances of the resident require.

Record review indicated that resident #008 experienced a bowel continence status change between three identified periods of time. The resident was described in Minimum Data Set (MDS) assessment as continent for bowel in the first identified time period, as usually continent in the second identified time period, and as occasionally incontinent in the third identified time period. There was no evidence of a bowel continence assessment completed using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence having been conducted within or after these periods of time.

Interviews with an identified registered nursing staff and the lead for the continence care and bowel management program confirmed that a bowel continence assessment was not conducted for the resident during the above mentioned periods when the resident's bowel continence level deteriorated from continent to occasionally incontinent within four months. [s. 51. (2) (a)]

2. Record review for resident #003 identified the resident's bladder and bowel continence level as being occasionally incontinent on an identified date, and as frequently incontinent six months later. There was no evidence of a continence assessment using a clinically appropriate assessment instrument when the resident's continence level changed from occasionally incontinent to frequently incontinent within or after the six months.

Interview with the ADOC, the lead for the continence program, confirmed that a continence assessment was not conducted between the above mentioned periods. [s. 51. (2) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that proper feeding techniques are used when assisting a resident with eating.

Observation conducted on December 9, 2014, during breakfast revealed that an identified PSW was standing while using a tablespoon to feed yogurt to resident #008.

Interview with an identified registered nursing staff confirmed that the PSW should have used a teaspoon to feed resident #008 instead, and that the PSW should have been seated while feeding the resident. [s. 73. (1) 10.]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

**s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

On December 3, 2013, at 2:00 p.m., the medication cart was observed to be unlocked on the west unit. There were no registered staff observed in the vicinity at the time.

Interview with an identified registered staff confirmed that the medication cart should have been locked while unsupervised. [s. 129. (1) (a)]

WN #15: 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:
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).

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:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all direct care staff are provided with training in skin and wound care in 2013.

Record review indicated that 41% of all direct care staff received skin and wound training in 2013.

Interviews with PSW, registered nursing staff and the ADOC confirmed that 59% of direct care staff were not provided skin and wound training in 2013. The home has a plan to provide the training to all direct care staff commencing in 2014. [s. 221. (1) 2.]

2. The licensee has failed to ensure that all staff who provide direct care to residents are provided training related to continence care and bowel management on an annual basis, or based on the staff's assessed training needs.

Record review revealed that only 14% of the direct care staff were provided with training related to continence care and bowel management in 2013.

Interview with the clinical care coordinator who is the lead for the continence care program confirmed that 86% of direct care staff did not receive the continence care training in 2013. [s. 221. (1) 3.]

3. The licensee has failed to ensure that all staff who provide direct care to residents, receive training relating to abuse recognition and prevention in 2013.

Record review indicated that 68% of all direct care staff at the home received training related to abuse recognition and prevention in 2013.

Interview with the ADOC confirmed that 32% of all direct care staff at the home did not receive abuse related training in 2013. [s. 221. (2)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases; O. Reg. 79/10, s. 229 (3).
(b) cleaning and disinfection; O. Reg. 79/10, s. 229 (3).
(c) data collection and trend analysis; O. Reg. 79/10, s. 229 (3).
(d) reporting protocols; and O. Reg. 79/10, s. 229 (3).
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Interviews with the program lead revealed that the infection prevention and control program had neither been evaluated nor updated in 2013. Interview with the DOC confirmed that the program had not been evaluated or updated at least annually. [s. 229. (2) (d)]

2. The licensee has failed to ensure that the designated infection prevention and control lead has education and experience in infection prevention and control practices including: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols, and outbreak management.

Interview with the infection prevention and control lead revealed that he/she does not have any formal education in infection prevention and control practices. Interview with the DOC confirmed that the designated infection control lead does not have any formal education in infection prevention and control practices. [s. 229. (3)]

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

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Issued on this 2nd day of February, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TILDA HUI (512), JOANNE ZAHUR (589), NICOLE RANGER (189), SOFIA DASILVA (567)
Inspection No. / No de l'inspection :	2014_251512_0022
Log No. / Registre no:	T-127-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 30, 2015
Licensee / Titulaire de permis :	EXTENDICARE TORONTO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE GUILDWOOD 60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	ANDRE BARROS

To EXTENDICARE TORONTO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with the requirement that drugs are administered to residents #009, #008, and #001, and any other residents in the home, in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

1. Record review for resident #009 revealed that medication prescribed for the resident was not administered in accordance with the directions for use specified by the prescriber. The resident's daily medication administration times for an identified medication A are 8:00 a.m. and 12:00 p.m. On the following occasions, medication A was recorded to be administered as follows:

-On December 10, 2014, the 8.a.m. scheduled administration was administered at 10:43 a.m. and the 12:00 p.m. was administered at 2:13 p.m.
-On December 7, 2014, the 12 p.m. scheduled administration was administered at 2:04 p.m.
-On December 6, 2014, the 8.a.m. scheduled administration was administered at 10:20 a.m. and the 12:00 p.m. was administered at 1:56 p.m.

2. Record review for resident #008 revealed that medication A is to be administered daily to the resident at 6 a.m., 10 a.m., 2 p.m., and 6 p.m. Review of the electronic medication administration record (eMar) revealed that medication A was administered at the following times, on the dates indicated:

-On December 10, 2014, the 6 p.m. scheduled administration was administered at 8:11 p.m.
-On December 4, 2014, the 10 a.m. scheduled administration was administered at 11:17 a.m.
-On November 30, 2014, 6.p.m. scheduled administration was administered at 9:42 a.m.

3. Record review for resident #001 revealed that medication A is to be administered to the resident at 8 a.m., 12 a.m., and 5 p.m. Review of the eMar revealed that medication A was administered at the following times, on the dates indicated:

-On December 11, 2014, the 8 a.m. scheduled administration was administered at 9:46 a.m.
-On December 9, 2014, the 8 a.m. scheduled administration was administered at 9:40 a.m.
-On December 7, 2014, the 8 a.m. scheduled administration was administered at 9:07 a.m.

Medication A contains an identified pharmaceutical ingredient which is commonly used to treat the symptoms of an identified group of neuro-musclular diseases with symptoms such as shakiness, stiffness, and difficulty moving. This identified disease is thought to be caused by too little of a naturally occurring substance in the brain. The identified pharmaceutical ingredient changes into this naturally occurring substance in the brain, helping to control movement. This medication is taken by mouth, usually 3 to 4 times a day or as directed by the doctor. This medication should be taken regularly to get the most benefit from it, and should be taken at the same times each day. Since a decrease in the effectiveness of this medication just before the next dose may be experienced in some populations, it is important to take it at the scheduled time.

4. Record review for resident #001 revealed that an identified medication B is to be administered to the resident daily at 8 a.m. Review of the eMar revealed that medication B was administered at the following times, on the dates indicated:

-On December 9, 2014, medication was administered at 10:23 a.m.
-On December 7, 2014, medication was administered at 10:27 a.m.
-On December 5, 2014, medication was administered at 9:42 a.m.

Medication B is one of the antiepileptic medications used to prevent epileptic seizures. It belongs to a class of medications called benzodiazepines, which act on the brain and nerves of the central nervous system to produce a calming effect. To get the most benefit from the medication, it should be taken consistently with the right dose at the right time. This medication may cause withdrawal reactions, especially if it has been used regularly for a long time or in high doses. In such cases, withdrawal symptoms such as headaches, trouble sleeping, restlessness, hallucinations/confusion, nausea, and seizures may occur if this medication is suddenly stopped.

5. Record review for resident #001 revealed that an identified medication C was to be administered to the resident daily at 8 a.m. Review of the eMar revealed that medication C was administered at the following times, on the dates indicated:

-On December 4, 2014, scheduled medication was administered at 11:11 a.m.
-On December 3, 2014, scheduled medication was administered at 11:09 a.m.
-On December 2, 2014, scheduled medication was administered at 11:01 a.m.

Medication C is an identified mineral supplement used to treat an identified medical condition. The mineral is best absorbed when taken on an empty stomach before or 2 hours after meals. It is important to take medication C exactly as prescribed or recommended by the doctor to keep up the level of effectiveness.

Interviews with the clinical care coordinator and the DOC confirmed that the above mentioned medications for the residents were not administered as specified by the prescribers, posing potential serious health risks to the residents for not administering the medications at the scheduled times. [s. 131. (2)] (567)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 27, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 30th day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Tilda Hui

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