Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 # / No de registre	Type of Inspection / Genre d'inspection
Sep 26, 2017	2017_644507_0010	020243-17	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 GUILDWOOD
60 GUILDWOOD PARKWAY SCARBOROUGH ON M1E 1N9

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

STELLA NG (507), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 23 – 25, 28 – 30, September 1, 5 – 8, and 11 – 12, 2017.

The following critical incident reports were inspected concurrently with the Resident Quality Inspection (RQI):
#004832-17, #018877-17 and #019342-17 related to resident to resident abuse and responsive behaviours,
#006443-17 and #008179-17 related to falls prevention, and
#008929-17 and #016494-17 related to transferring and positioning.

The following complaints were inspected concurrently with the RQI:
#032559-16 related to falls prevention and continence care,
#006280-17 related to pain management, transferring and positioning, plan of care and continence care and bowel management,
#008090-17 related to falls prevention, and
#009696-17 related to abuse prevention and responsive behaviours.

The following follow-up inspection was inspected concurrently with the RQI:
#005129-17 related to abuse prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, Directors of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Clinical Coordinator (CC), Social Worker (SW), Physiotherapist (PT), Dietary Aides (DA), residents, substitute decision makers (SDMs) and family members of residents.

The inspectors conducted tour of the home, observations of staff and resident interactions, provision of care, medication administration, dining and snack services, record review of resident and home records, staffing schedules, relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours

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

6 WN(s)
3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2016_377502_0012	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. 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 resident #013 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident between residents#012 and #013 which resulted in an injury to resident #013.

Review of the CIS and progress notes for residents #012 and #013 revealed that on an identified date, at an approximate time, resident #013 approached and spoke to resident #012. Resident #013 continued to speak to resident #012 despite being asked to leave by resident #012. Resident #012 then pushed resident #013 which resulted in an injury to resident #013. Review of the home's investigation notes revealed that resident #012 stated that on the specified date, he/she was sitting in the common area, was approached and yelled at by resident #013. Resident #012 asked resident #013 to leave, but resident #013 remained yelling at his/her ear. Resident #012 pushed resident #013 away resulting resident #013 sustained an injury.

Review of the home's surveillance camera recording revealed that on the above mentioned date, at an approximate time, resident #012 was seen sitting in the common area. Ten minutes later, resident #013 was seen approaching resident #012 and appeared to be speaking to resident #012. Twenty seconds later, resident#012 was seen pushing resident #013.

In interviews, resident #012 stated he/she did not push another resident on any given days. Resident #013 stated he/she was pushed from the side. Resident #013 further stated that he/she was able to recognize the person who pushed him/her, but not able to describe the person to the inspector. Resident #021 stated he/she witnessed resident #013 approached resident #012 and resident #012 pushed resident #013 on the above mentioned date.

B) Review of resident #013's progress notes revealed the following:
- On an identified date, the resident slapped his/her roommate because the roommate was making noises.
- On a second identified date, the resident yelled at a co-resident, and pulled the co-resident's hair.
- On a third identified date, the resident pushed another co-resident into the co-resident's room, tightened the clothes around co-resident's neck and hit the co-resident in the head.
- On a fourth identified date, the resident walked towards a co-resident, told the co-resident to move and attempted to push the co-resident's chair. When the co-resident

said "no", the resident hit the co-resident in the face.
- On a fifth identified date, the resident walked to a co-resident, swung at the co-resident's face, then walked away.

C) Review of resident #013’s progress notes revealed that on an identified date, resident #013 slapped his/her roommate because the roommate was making noises. Resident #013 was placed on a seven days observation using the Dementia Observation System (DOS) tool from the date of the incident.

Review of the instructions for completing DOS revealed the following:
- DOS tool is used to assess a person’s behaviour over a 24 hour cycle for up to seven days to determine the occurrence, frequency, and duration of concern.
- DOS tool is used to evaluate the effectiveness of a planned intervention on the care-plan that is addressing specific target behaviours.
- Record the behaviour in 30 minute intervals for the duration of up to seven days to determine trends.
- For each 24 hour column, calculate the number of hours spent in sleep, calmness, restlessness, verbal aggression/agitation and physical aggression.
- Summarize the analysis in the person’s progress records with a note that describes the total number of days of the record, range of hours spent in each category of behaviour and any significant negatives.

Review of the DOS monitoring record revealed that resident #013’s behaviour monitoring was completed for seven days from the date of the above mentioned incident. Review of resident #013’s progress notes failed to reveal the analysis of the above mentioned DOS monitoring.

D) Review of resident #013’s Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed on an identified date, revealed that resident #013 exhibited responsive behaviour up to five days during the seven days observation period prior to the RAI-MDS assessment.

Review of the Behavioural Supports Ontario (BSO) round on two identified dates revealed that resident #013’s responsive behaviour was discussed, and recommendations were made.

Review of resident #013’s plan of care completed on an identified date, failed to reveal a section including the focus, goal and interventions for the resident’s responsive

behaviour.

In interviews, staff #104, #115, #106 and #116 stated that resident #013 tended to exhibit responsive behaviour with other residents and upset them. Staff #104, #106, #115, #116 and #118 stated that staff were to monitor resident #013 at all times. Redirection, distraction, talking and listening to the resident and music program would be provided when resident #013 was in close vicinity with other residents.

In interviews, staff #106 and #117 stated the registered staff are responsible for documenting the analysis of DOS monitoring in the resident's progress notes and updating the written plan of care accordingly. Staff #106 and #117 confirmed that the analysis of resident #013's DOS monitoring for the above mentioned period was not completed, and the evaluation of the effectiveness of resident #013's planned intervention on the written plan of care in addressing his/her responsive behaviour were not completed as indicated in the instruction of completing the DOS tool. Staff #117 and #118 acknowledged that there were documentation in relation to resident #013's responsive behaviour towards other residents, and interventions were not implemented to ensure the safety of resident #013 and other residents.

The severity is actual harm related to resident #013, and the scope is isolated. Compliance history revealed two previous orders with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) were issued under inspection reports #2015_369153_0003 dated March 13, 2015 and inspection report #2016_377502_0012 dated December 22, 2016. As a result, a Compliance Order is warranted. [s. 19. (1)]

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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

An identified CIS was submitted to the MOHLTC on an identified date related to an incident between residents #012 and #013. The CIS revealed that resident #012 pushed resident #013 which resulted in an injury to resident #013.

Review of resident #013's progress notes revealed the following:
- On an identified date, the resident slapped his/her roommate because the roommate was making noises.
- On a second identified date, the resident yelled at a co-resident, and pulled the co-resident's hair.
- On a third identified date, the resident pushed another co-resident into the co-resident's room, tightened the clothes around co-resident's neck and hit the co-resident in the head.
- On a fourth identified date, the resident walked towards a co-resident, told the co-resident to move and attempted to push the co-resident's chair. When the co-resident said "no", the resident hit the co-resident in the face.
- On a fifth identified date, the resident walked to a co-resident, swung at the co-resident's face, then walked away.

Review of resident #013's RAI-MDS assessment completed on an identified date revealed that resident #013 exhibited responsive behaviour up to five days during the seven days observation period prior to the RAI-MDS assessment.

Review of the BSO round on two identified dates revealed that resident #013's responsive behaviour was discussed, and recommendations were made.

Review of resident #013's plan of care completed on an identified date failed to reveal a section including the focus, goal and interventions for the resident's responsive behaviour.

In interviews, staff #104, #115, #106 and #116 stated that resident #013 tended to exhibit responsive behaviour with other residents and upset them. Staff #104, #106, #115, #116 and #118 stated that staff were to monitor resident #013 at all times. Redirection, distraction, talking and listening to the resident and music program would be provided when resident #013 was in close vicinity with other residents.

In interviews, staff #106 and #117 stated the registered staff are responsible for developing and updating the resident's written plan of care. Staff #117 confirmed that resident #013's written plan of care did not include the resident's above mentioned responsive behaviours. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

An identified CIS was submitted to the MOHLTC on an identified date related to an injury of unknown cause to resident #007.

Record review of resident #007's CIS and progress notes on an identified date revealed resident #007 complained of pain during care and was unable to extend one of his/her limbs and notable swelling was present. No reports of any recent falls. Last documented fall was two months prior. The doctor was notified and resident #007 was transferred to the hospital for further assessment. Further record review of resident #007's progress notes dated the following day revealed the hospital informed the home that resident #007 was admitted with an injury.

Record review of resident #007's progress notes on the identified date revealed a staff member put resident #007 on the toilet and requested the resident to wait ten minutes until he/she returned. When the staff member returned resident #007 had already transferred him/herself back to the chair. Later the day, the staff member reported to the RPN that resident #007 complained of pain. The RPN mentioned to the staff member

that the resident had received scheduled analgesic. The staff member reassured resident #007 and the resident settled in bed soon after and back to sleep.

Record review of resident #007's progress notes on the above mentioned date, revealed resident #007 complained of pain during care and was unable to extend one of his/her limbs and notable swelling was present. No reports of any recent falls. Last documented fall was two months prior. The doctor was notified and resident #007 was transferred to the hospital for further assessment. Further record review of resident #007's progress notes dated the following day revealed the hospital informed the home that resident #007 was admitted with an injury.

Record review of resident #007's progress notes dated six weeks later, revealed resident #007’s above mentioned injury report was reviewed by the home's attending physician who mentioned resident #007's injury required treatment. The nurse contacted the hospital and resident #007 was transferred to the hospital. A progress note dated the following date mentioned that the hospital called the home and enquired about resident #007’s injury. A progress note dated three days later, revealed resident#007 was admitted to the hospital.

Record review of the home’s investigation contact form on an identified date revealed that on that day, staff #129 provided care to resident #007 and the resident was transferred to toilet by staff #129 who attended to a call bell and came back and saw that resident #007 had transferred him/herself from toilet to chair. Staff #129 then transferred resident #007 to bed, resident #007 complained of pain. Charge Nurse was notified. Resident was transferred to hospital the following day. This form also revealed upon return from hospital staff # 117 and #130 interviewed resident #007 and the resident said that he/she rolled out of bed. Resident #007 was a two person transfer and staff #129 transferred the resident from chair to bed unassisted. The records also revealed staff #129 received disciplinary actions for not providing care to resident #007 as per plan of care.

Record review of resident #007’s written plan of care in effect on two identified dates revealed resident #007 required extensive assistance for transfer by two staff and as needed mechanical lift.

Resident #007 could not be interviewed he/she was discharged from the home prior to the inspection.

Interview with staff #129 revealed he/she put resident #007 on the toilet and requested the resident to wait until he/she returned. Staff #129 also mentioned that he/she left resident #007 on the toilet to respond to another resident's call bell and when he/she returned resident #007 had transferred him/herself back to the chair. Staff #129 also mentioned he/she transferred resident #007 back to bed without the assistance of another staff member.

Interview with staff #131 revealed he/she was aware of resident #007's written plan of care which required resident #007 to be transferred with the assistance of two staff members or the use of the mechanical lift. Staff #131 mentioned he/she did transfer resident #007 without the assistance of another staff member.

Interview with staff #117 revealed that there were no evidence to support that resident #007 sustained a fall in the above mentioned month when he/she complained of pain or sustained injury two months later.

Interview with the staff #130 revealed he/she investigated the circumstances regarding resident #007's injury of unknown cause and the outcome of the investigation revealed that staff #129 transferred resident #007 by him/herself and did not seek the assistance of another staff member as per resident #007's plan of care. He/she also mentioned that staff #131 also transferred resident #007 on a different shift by him/herself and did not seek the assistance of another staff member as per resident #007's plan of care. Both staff members received disciplinary actions and education on safe transfers and positioning techniques. Staff #130 also mentioned that he/she spoke to resident #007 upon his/her return from hospital and the resident revealed he/she had rolled out of bed however did not provide further details or how he/she returned to his/her bed. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning techniques when assisting residents.

Record review of an identified CIS on an identified date revealed a staff member had attempted to transfer resident #006 from bed to chair by holding the resident. As a result the resident had sustained altered skin integrity.

Record review of resident #006's progress notes on an identified date revealed resident #006 went to the nursing station and reported to staff #125 that he/she has altered skin integrity.

Record review of resident #006's progress notes dated the following date revealed staff #120 was called to address resident #006's concern and resident #006 was received looking upset and signs of altered skin integrity.

Record review of resident #006's written plan of care dated two months prior revealed the resident required extensive assistance with one staff to provide some physical assistance and a second staff present.

Interview with resident #006 revealed that resident #006 sustained altered skin integrity when the staff member transferred him/her from bed to chair.

Interviews with staff #125, #111 and #120 revealed that resident #006 sustained altered skin integrity.

Interview with staff #126 revealed he/she held resident #006's when transferring him/her from the bed to the chair.

Interview with staff #128 revealed staff #126 held resident #006 to transfer him/her from bed to chair and the resident was noted to have altered skin integrity. Staff #128 also revealed staff #126 received disciplinary actions as a result of the incident and received training on safe transferring and positioning techniques. [s. 36.]

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 staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations.

Review the home's instruction for completing DOS revealed the following:
- DOS tool is used to assess a person's behaviour over a 24 hour cycle for up to seven days to determine the occurrence, frequency, and duration of concern.
- DOS tool is used to evaluate the effectiveness of a planned intervention on the care-plan that is addressing specific target behaviours.
- Record the behaviour in 30 minute intervals for the duration of up to seven days to determine trends.
- For each 24 hour column, calculate the number of hours spent in sleep, calmness, restlessness, verbal aggression/agitation and physical aggression.

- Summarize the analysis in the person’s progress records with a note that describes the total number of days of the record, range of hours spent in each category of behaviour and any significant negatives.

A) An identified CIS was submitted to the MOHLTC on an identified date, related to an incident between residents #012 and #013. The CIS revealed that resident #012 pushed resident #013 resulting resident #013 sustained injury.

Review of resident #013’s progress notes revealed that on an identified date six months prior, resident #013 slapped his/her roommate because the roommate was making noises. Resident #013 was placed on a seven days observation using the Dementia Observation System (DOS) tool from the above mentioned identified date.

Review of the DOS record revealed that resident #013’s behaviour monitoring was completed for seven days after the above mentioned incident. Review of resident #013’s progress notes failed to reveal the analysis of the above mentioned DOS monitoring.

B) On an identified date, the MOHLTC received a complaint in relation to altercation incidents between residents.

Review of resident #022’s progress notes revealed that on an identified date, resident #022 kicked resident #011 which resulted in resident #011 sustaining an altered skin integrity. Resident #022 was placed on a seven days observation using the DOS tool from the above mentioned date.

Review of the DOS record revealed that resident #022’s behaviour monitoring was completed for seven days after the above mentioned incident. Review of resident #022’s progress notes failed to reveal the analysis of the above mentioned DOS monitoring.

In interviews, staff #106 and #117 stated the registered staff are responsible for documenting the analysis of DOS monitoring in the resident’s progress notes. Staff #106 and #117 confirmed that the analysis of residents #013 and #22’s DOS monitoring for the above mentioned periods were not completed.

In interview, staff #117 acknowledged that the DOS monitoring were completed for residents #013 and #022 for seven days for the above mentioned periods; however, the analysis of the DOS monitoring and evaluation of the effectiveness of the planned intervention on the care-plan that were addressing the responsive behaviours were not

completed for both residents. [s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations, 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 was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

An identified CIS was submitted to the MOHLTC on an identified date related to a fall incident that had occurred five days earlier. The CIS revealed resident #008 had experienced a fall which resulted in a transfer to hospital.

Two days after the above mentioned fall incident, the MOHLTC received a complaint lodged by resident #008's substitute decision maker (SDM) related to the falls prevention and management of resident #008.

Review of the progress notes of resident #008 revealed that the resident had experienced a fall on an identified date. The progress notes further revealed resident #008 notified staff that he/she had fallen.

Review of the home’s Falls Prevention and Management Program policy (RC-15-01-01), revised February 2017 indicated a post-fall assessment by using the Post - Fall Assessment Tool as soon as possible is part of the post fall management. Review of the Post - Fall Assessment Tool indicated the assessment tool included the following categories:
- Assessment,
- risk review,
- root cause analysis,
- medications,
- care plan, and
- referrals.

In interviews, staff #123, #124, and #117 stated that registered staff are required to complete a post fall assessment by using the Falls Management – Post Fall Assessment template on the computer when a resident has fallen.

Review of the Falls Management – Post Fall Assessment dated on the above mentioned date for resident #008 revealed that the resident had experienced a fall on that day. Further review of the same post fall assessment revealed that risk review, root cause analysis, medications, care plan and referrals categories were not completed.

In interview, staff #117 confirmed that the post fall assessment for resident #008’s fall occurred on the above mentioned date was not completed as required. [s. 49. (2)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a written record was kept of the quarterly review undertaken of all medication incidents and adverse drug reactions that has occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions and (b) any changes and improvements identified in the review were implemented; and (c) a written record was kept of everything provided for in clauses (a) and (b).

Record review of the home's professional advisory committee/medical meeting minutes on an identified date revealed medication incident reports were discussed and the recommended actions noted were that medical pharmacies would have a template on line in Policy and Procedure Manual. This document did not provide supporting evidence that a review of all medication incidents and adverse drug reactions had been reviewed and any changes and improvement identified.

Record review of the home's medication incident reports revealed eight medication incidents in a period of 16 months.

Interview with staff #117, #132 and #130 revealed a discussion was held regarding the medication incidents at the professional advisory committee meeting however there was no written record to support the quarterly review of the homes medication incidents and adverse drug reactions. [s. 135. (3)]

Issued on this 10th day of October, 2017

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STELLA NG (507), GORDANA KRSTEVSKA (600), NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2017_644507_0010
Log No. / No de registre :	020243-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 26, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) 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 :	Zafulah Rahaman

To EXTENDICARE (CANADA) 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 :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all residents are protected from physical abuse from other residents. The plan shall include, but not be limited to the following:

1) The development and implementation of a system of ongoing monitoring to ensure staff complete the analysis of the dementia observation system monitoring record, and the evaluation of the residents' planned interventions on the care plans in addressing the residents' aggressive behaviours towards other residents,
2) Review the plan of care of resident #013 and other residents who exhibited aggressive behaviours towards other residents to include a focus, goal, and interventions to address the aggressive behaviours and ensure staff are aware of the content of the care plan, and
3) Provide education to all registered staff to ensure that all dementia observation system monitoring are analyzed and the planned interventions are evaluated for effectiveness.

This plan is to be submitted via email to inspector - stella.ng@ontario.ca by October 12, 2017.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #013 was protected from abuse by anyone and free from neglect by the licensee or staff in the home.

A) An identified critical incident system report (CIS) was submitted to the Ministry of Health and Long Term Care (MOHLTC) related to an incident between residents #012 and #013 which resulted in an injury to resident #013.

Review of the CIS and progress notes for residents #012 and #013 revealed that on an identified date, at an approximate time, resident #013 approached and spoke to resident #012. Resident #013 continued to speak to resident #012 despite being asked to leave by resident #012. Resident #012 then pushed resident #013 which resulted in an injury to resident #013. Review of the home's investigation notes revealed that resident #012 stated that on the specified date, he/she was sitting in the common area, was approached and yelled at by resident #013. Resident #012 asked resident #013 to leave, but resident #013 remained yelling at his/her ear. Resident #012 pushed resident #013 away resulting resident #013 sustained an injury.

Review of the home's surveillance camera recording revealed that on the above mentioned date, at an approximate time, resident #012 was seen sitting in the common area. Ten minutes later, resident#013 was seen approaching resident #012 and appeared to be speaking to resident #012. Twenty seconds later, resident #012 was seen pushing resident #013.

In interviews, resident #012 stated he/she did not push another resident on any given days. Resident #013 stated he/she was pushed from the side. Resident #013 further stated that he/she was able to recognize the person who pushed him/her, but not able to describe the person to the inspector. Resident #021 stated he/she witnessed resident #013 approached resident #012 and resident #012 pushed resident #013 on the above mentioned date.

B) Review of resident #013's progress notes revealed the following:
- On an identified date, the resident slapped his/her roommate because the roommate was making noises.
- On a second identified date, the resident yelled at a co-resident, and pulled the co-resident's hair.
- On a third identified date, the resident pushed another co-resident into the co-resident's room, tightened the clothes around co-resident's neck and hit the co-resident in the head.
- On a fourth identified date, the resident walked towards a co-resident, told the co-resident to move and attempted to push the co-resident's chair. When the co-resident said "no", the resident hit the co-resident in the face.
- On a fifth identified date, the resident walked to a co-resident, swung at the co-resident's face, then walked away.

C) Review of resident #013's progress notes revealed that on an identified date, resident #013 slapped his/her roommate because the roommate was making noises. Resident #013 was placed on a seven days observation using the Dementia Observation System (DOS) tool from the date of the incident.

Review of the instructions for completing DOS revealed the following:
- DOS tool is used to assess a person's behaviour over a 24 hour cycle for up to seven days to determine the occurrence, frequency, and duration of concern.
- DOS tool is used to evaluate the effectiveness of a planned intervention on the care-plan that is addressing specific target behaviours.
- Record the behaviour in 30 minute intervals for the duration of up to seven days to determine trends.
- For each 24 hour column, calculate the number of hours spent in sleep, calmness, restlessness, verbal aggression/agitation and physical aggression.
- Summarize the analysis in the person's progress records with a note that describes the total number of days of the record, range of hours spent in each category of behaviour and any significant negatives.

Review of the DOS monitoring record revealed that resident #013's behaviour monitoring was completed for seven days from the date of the above mentioned incident. Review of resident #013's progress notes failed to reveal the analysis of the above mentioned DOS monitoring.

D) Review of resident #013's Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment completed on an identified date, revealed that resident #013 exhibited responsive behaviour up to five days during the seven days observation period prior to the RAI-MDS assessment.

Review of the Behavioural Supports Ontario (BSO) round on two identified dates revealed that resident #013's responsive behaviour was discussed, and recommendations were made.

Review of resident #013's plan of care completed on an identified date, failed to reveal a section including the focus, goal and interventions for the resident's responsive behaviour.

In interviews, staff #104, #115, #106 and #116 stated that resident #013 tended to exhibit responsive behaviour with other residents and upset them. Staff #104, #106, #115, #116 and #118 stated that staff were to monitor resident #013 at all

times. Redirection, distraction, talking and listening to the resident and music program would be provided when resident #013 was in close vicinity with other residents.

In interviews, staff #106 and #117 stated the registered staff are responsible for documenting the analysis of DOS monitoring in the resident's progress notes and updating the written plan of care accordingly. Staff #106 and #117 confirmed that the analysis of resident #013's DOS monitoring for the above mentioned period was not completed, and the evaluation of the effectiveness of resident #013's planned intervention on the written plan of care in addressing his/her responsive behaviour were not completed as indicated in the instruction of completing the DOS tool. Staff #117 and #118 acknowledged that there were documentation in relation to resident #013's responsive behaviour towards other residents, and interventions were not implemented to ensure the safety of resident #013 and other residents.

The severity is actual harm related to resident #013, and the scope is isolated. Compliance history revealed two previous orders with LTCHA, 2007 S.O. 2007, c.8, s. 19 (1) were issued under inspection reports #2015_369153_0003 dated March 13, 2015 and inspection report #2016_377502_0012 dated December 22, 2016. As a result, a Compliance Order is warranted. [s. 19. (1)]
(507)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 08, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 26th day of September, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : STELLA NG

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