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 prévue le Loi de 2007 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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 01, 2018;	2018_712665_0005 (A1)	006704-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Scarborough
3830 Lawrence Avenue East SCARBOROUGH ON M1G 1R6

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

Ontario

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Amended by JOY IERACI (665) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

No changes made to the Public Reports.

Issued on this 1 day of August 2018 (A1)

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

Original report signed by the inspector.

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Amended by JOY IERACI (665) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): April 10, 11, 12, 13, 17, 18, 19, 20, 23, 24, 25, 26, 27, 30, May 1, 2, 3, 4, 7 (off-site), 2018.

The Follow-Up Log #000413-18 was inspected concurrently in this RQI.

The following Critical Incident System (CIS) and Complaint intakes were inspected concurrently in this RQI:

Complaint Log #005599-17 related to alleged neglect

Complaint Log #005122-18 related to admission to the home

CIS Log #006127-17, CIS #2117-000005-17 related to alleged abuse

CIS Log 008266-18, CIS #2117-000005-18 related alleged abuse

CIS Log #027352-17, CIS #2117-000017-17 related to fall prevention and management

CIS Log #003337-18, CIS #2117-00003-18 related to transferring and positioning

CIS Log #029385-17, CIS #2117-000018-17 related to skin and wound care

CIS Log #025779-17, CIS #2117-000015-17 related to skin and wound care

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Dietary Manager (DM), Support Services Manager (SSM), Registered Dietitian (RD), Physiotherapist (PT), Resident Assessment Instrument-Minimum Data Set (RAI-MDS) Coordinator, Registered Nurses (RN), Skin and Wound Champion (SWC), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Program Aide, Dietary Aide (DA), Housekeeping Aide (HSK), Maintenance Staff, Senior Placement Services Manager at the Central East Local Health Integration Network (LHIN), Placement Services Coordinator at the Central East LHIN, Family Council President, family members and residents.

The inspectors also conducted a tour of the home including resident home areas, medication administration observations, provision of care observations, staff and resident interactions, reviewed clinical health records, reviewed meeting minutes, training records, relevant home policies and procedures and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

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

Minimizing of Restraining

Nutrition and Hydration

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

8 WN(s)
4 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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. 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 used safe transferring and positioning devices or techniques when assisting residents.

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report (CIS) #2117-000003-18 on an identified date in 2018, for an incident

that occurred four days earlier.

The CIS indicated the MOHLTC had been notified on the day of the incident and the home had been provided with report #18568. The CIS further indicated while being transported in a wheelchair by Personal Support Worker (PSW) #126 from the washroom to their bed resident #014 fell out of the wheelchair sustaining an injury that required a transfer to hospital for an identified treatment.

Review of resident #014's health record indicated they had been admitted to the home on an identified date in 2014. Further review of the health record indicated a decline in resident #014's health status related to an identified medical diagnosis and now required extensive assistance with all transfers by two staff. Review of the written plan of care in Point Click Care (PCC) indicated resident #014 was at an identified risk for falls.

In an interview, PSW #126 stated they had been toileting resident #014 as per normal routine before the resident’s identified activity of daily living (ADL). PSW #126 further stated after transferring resident #014 into the wheelchair after toileting, they had not positioned resident #104 properly in the wheelchair. PSW #126 stated they were standing behind the wheelchair when resident #014 began to fall and the PSW attempted to prevent the fall; however, resident #014 fell onto the floor. PSW #126 acknowledged that resident #014 had not been positioned properly in the wheelchair.

In an interview with resident #014, they did not remember the above mentioned fall incident.

Review of PSW #126's personnel file indicated they had received discipline based on their failure to ensure resident safety when transporting the resident, violation of the home's policies and procedures, employee standards of conduct and Resident's Rights. The home also wrote that PSW #126 had neglected to provide a safe environment and imposed a huge risk to the resident's well-being and care.

In an interview, Director of Care (DOC) #120 who was also the lead for the Falls Prevention program in the home verified that PSW #126 had failed to ensure staff used safe transferring and positioning techniques when assisting resident #014.

2. A follow-up inspection was conducted concurrently with the resident quality inspection (RQI) related to compliance order O. Reg., s. 36, served under

inspection number #2017_626501_0022, specific to PSW #109's transferring techniques. As resident #010 no longer resided in the home, observations of PSW #109 conducting resident transfers were expanded to include residents #045 and #044.

Review of resident #045's health record indicated they had been admitted to the home on an identified date in 2018, with underlying health conditions.

Further review indicated resident #045 was dependent for all aspects of positioning, requiring total assistance and transferring with an identified mechanical lift. An identified assessment completed on admission identified the type of sling to be used for transferring the resident.

Review of in-service records for PSW #109 indicated they had received education on transfers, mechanical lifts, received a certificate for safe patient transfer by the home's physiotherapist and importance of shift change on two identified dates in 2017 and 2018.

In an interview, physiotherapist (PT) #129 stated that PSW #109 had demonstrated an understanding of safe patient transfers after receiving education on an identified date in 2017.

On April 23, 2018, observations by the Inspector indicated PSW #109 had used another type of sling on an identified mechanical lift to transfer resident #045 from bed into an identified chair with the assistance of a co-worker. PSW #109 stated resident #045 had been transferred safely with the sling on prior occasions. Further observations indicated resident #045's body and identified extremities were in an identified way and the two PSWs experienced some difficulty maneuvering resident #045's identified area of the body around the mechanical lift and into the identified chair.

During a conversation with resident #045 they stated during the above mentioned transfer an identified area of the body was sore as it felt like it had not been supported.

Review of the manufacturer's recommendations, for use of the identified sling used in the transfer with PSW #109 above, indicated that the sling had been specifically designed to be used from a sitting position with either a patient lift or a stand aid. The recommendations further indicated this sling had been specifically designed

for toileting and hygiene functions.

Review of the identified assessment completed on admission by registered nurse (RN) #123 indicated resident #045 had been assessed to be transferred with an identified sling, different from the identified sling used by PSW #109 noted above. RN #123 could not recall receiving training on how to assess a resident for proper sling size and type however, they assess a resident visually, by following the identified assessment tool and at times will also take the transferring care needs from the resident's RAI-MDS admission package.

In an interview, PT #129 stated the identified sling used by PSW #109 was not an appropriate sling for resident #045 due to their identified functional abilities and that the identified sling noted in the identified assessment by RN #123 should have been used for all transfers.

In an interview, DOC #120 verified that PSW #109 had not used safe transferring and positioning devices or techniques when assisting resident #045.

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 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 stairways are kept closed and locked.

On an identified date in 2018, observations conducted by the Inspector during the initial tour of the home indicated the basement’s north and south stairwell doors were unlocked and unsupervised. The south stairwell had two flights of stairs that led to a locked kitchen door and the north stairwell had stairs that led to the first and second floors of the home, as well as to a locked door that lead to the home's back garden. Further observations indicated the basement had resident spaces that included the program room, the offices of the Social Worker (SW) and Program Manager (PM) and directly to the right of the elevator doors, there were three bookshelves that consisted of a resident library.

In an interview, PSW #142 acknowledged that 12 days after the initial tour observations by the Inspector, on an identified date in 2018, at an identified time, they had heard the stairwell door closing and when they looked down an identified resident home area’s (RHA) hallway, they observed resident #043 had exited the stairwell door and then proceeded to walk into an identified common area in the RHA.

Observations that were conducted by the Inspector 13 days after the initial tour observations, related to compliance order follow-up inspection #2017_626501_0022; where the home had been ordered to ensure all staff attend morning shift report prior to giving care to residents, RN #132 indicated resident #043 had been observed exiting the north stairwell door on an identified RHA, at an identified time by a PSW working on the identified RHA.

The shift report also indicated staff were uncertain how resident #043 had gained access to the stairwell; however, they assumed resident #043 had accessed the north stairwell from the basement as the resident knew the elevator code and took the stairs to the identified RHA. Review of resident #043's progress notes indicated that resident #043 had been observed walking through a common area of the identified RHA before entering the elevators and returned to their unit.

In an interview, PSW #142 acknowledged on an identified date in 2018, at an identified time, they had heard the stairwell door closing and when they looked down an identified RHA’s hallway, they had observed resident #043 had exited the stairwell door and then proceeded to walk into an identified common area.

In an interview, Administrator #126 stated that residents would require the elevator access code to get to the basement and that residents were not aware of the elevator access code.

Inspector conducted an interview with resident #043 with the assistance of Inspector #726 to interpret because of a language barrier. During the interview, resident #043 had not answered the questions appropriately; therefore, the interview was ended.

Review of resident #043's health record indicated an identified assessment had been completed three months prior to the above observations, which indicated the resident's cognitive status. Further review of resident #043's plan of care in place at the time of this inspection indicated their physical functioning, health conditions and interventions when attempts were made to use the stairs.

Review of resident #043's progress notes indicated that over a period of three months on identified dates in 2017 and 2018, there were three occasions where resident was found in the basement and stairwell. The resident had an identified incident with no injuries at one of the occasions in 2017. These three occasions occurred prior to the observations made by PSW #142 noted above.

Video surveillance from the basement on an identified date in 2018, indicated resident #043 had been walking in the basement hallway at an identified time alone. The video surveillance further indicated resident #043 had knocked on an identified non-residential room at a specified time and when not answered they proceeded in the hallway towards the north stairwell doors at an identified time. The video surveillance confirmed PSW #142's observations above.

In an interview, PSW #136 had recalled that on one occasion resident #043 went on the elevator at the same time as them and proceeded to enter the basement access code on the elevator keypad unassisted. PSW #136 further stated they both went to an identified non-residential room. PSW #136 could not recall the actual date but only that it had occurred this year. PSW #136 further stated resident #043 would routinely go the identified non-residential room unassisted.

In an interview, PT #129 stated that due to resident #043's identified health conditions, they were not to access the stairs.

In an interview, Administrator #126 verified the licensee had failed to ensure that all doors leading to stairways were locked when not being supervised by staff.

2. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

Observations made during the initial tour of the home, the Inspector observed an identified non-residential room in an identified RHA that had been left unlocked and unsupervised.

Further observations by the Inspector indicated the identified non-residential room's door latch had been stuffed with paper towel preventing the door from locking once closed. Inside the identified room was a housekeeper's cart, chemicals on shelves and a chemical dispensing unit that contained three identified chemicals.

Observations also indicated the identified non-residential room was located directly beside a common area that had approximately 14 residents present with three to four of them ambulatory with walkers.

The Assistant Director of Care (ADOC) #107 was on the identified RHA at the time of the above mentioned observation and the door latch stuffed with paper towel was brought to their attention. ADOC #107 stated that this practice was unacceptable and that the home's expectation was that all non-residential doors are to be locked at all times.

In an interview, housekeeper (HSK) #121 working on the identified home area on the same day of the observation stated they had not put the paper towel in the door latch, and had not noticed it was there when they had started their shift. HSK #121 further stated they were aware that the identified non-residential room door was to be kept locked at all times.

ADOC #107 verified the home had failed to ensure the identified non-residential room door had been kept locked when not being supervised by staff.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007, 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Resident #009 was triggered from stage one of the RQI for altered skin integrity through the MDS assessment.

Review of resident's MDS assessment on an identified date in 2018, inidcated resident #009 had an area of altered skin integrity.

Resident #009 was admitted to the home on an identified date in 2017. Review of the admission note and an identified assessment dated one day after admission, indicated resident had identified areas of altered skin integrity to an area of the body and received treatment. Review of the resident's identified assessments indicated one month after admission, one area of the resident's altered skin integrity worsened and had healed 16 days later. Twenty days later, an identified assessment indicated the resident had multiple areas of altered skin integrity to the same area of the body.

Review of the written plan of care indicated the focus for altered skin integrity had been initiated when resident had multiple areas of altered skin integrity noted above. The written plan of care did not have a focus for altered skin integrity on admission.

In interviews with registered practical nurses (RPNs) #113 and #103, they indicated when a resident has altered skin integrity, it is the home's expectation for the written plan of care to include the altered skin integrity and interventions upon discovery. The RPN's reviewed the written plan of care of the resident and indicated the focus for altered skin integrity had only been initiated in the written plan of care 59 days after admission. Both RPNs stated the resident's area of altered skin integrity on admission was to have been initiated in the written plan of care with the interventions when resident had been admitted to the home.

In an interview, the home's Skin and Wound Champion (SWC) RPN #118, indicated upon discovery of altered skin integrity, an identified assessment was to be completed and the written plan of care must be updated with interventions to manage the altered skin integrity. The SWC RPN reviewed resident's written plan of care and acknowledged the written plan of care did not set out the planned care for resident #009 upon discovery of their identified altered skin integrity since admission, as per the home's expectation.

In an interview, ADOC #107, indicated when a resident has altered skin integrity, an identified assessment was to be completed and then it is put into written plan of care with interventions. The ADOC reviewed the written plan of care and indicated it was not revised to include the planned care for the area of altered skin integrity on admission. The ADOC acknowledged that resident #009 did not have a written plan of care for the altered skin integrity to the identified area of the body on admission as per the home's expectation.

2. Resident #012 was triggered from stage one of the RQI for altered skin integrity through the MDS assessment.

Review of resident's MDS assessment on an identified date in 2018, indicated resident #012 had an identified type of altered skin integrity. Record review of the progress notes and identified assessments indicated about one month prior to the completion of the MDS assessment, resident had an identified area of altered skin integrity.

Review of the written plan of care indicated the focus for altered skin integrity noted above was initiated three months after discovery.

In interviews with RPNs #116 and #147, they indicated when a resident has altered skin integrity, it is the home's expectation for the written plan of care to include the altered skin integrity and the interventions. RPN #116 reviewed the written plan of care of the resident and indicated the focus for altered skin integrity had been initiated in the written plan of care on an identified date in 2018, and should have been updated three months earlier upon discovery of the altered skin integrity.

In an interview, RN #132, stated it is the home's expectation upon discovery of altered skin integrity, an identified assessment was to be completed and the written plan of care updated under the altered skin integrity focus. RN #132 indicated they completed the identified assessment upon discovery of the resident's altered skin integrity, but missed updating the written plan of care with the interventions as per the home's expectation.

In an interview, SWC RPN #118 indicated upon discovery of altered skin integrity, an identified assessment was to be completed and the written plan of care must be updated with interventions to manage the altered skin integrity. The SWC RPN reviewed the resident's written plan of care and acknowledged the written plan of

care did not set out the planned care for resident #012 upon discovery of their altered skin integrity, as per the home's expectation.

In an interview, ADOC #107 indicated when a resident has altered skin integrity, an identified assessment was to be completed and then it is put into written plan of care with interventions. The ADOC reviewed the written plan of care and indicated the written plan of care was not revised to include the planned care for the resident's altered skin integrity upon discovery. The ADOC acknowledged that resident #012 did not have a written plan of care for the altered skin integrity upon discovery, as per home's expectation.

3. The licensee has failed to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provided direct care to the resident.

Resident #005 was triggered for continence care during stage one of the RQI.

Record review of the RAI-MDS assessment completed on an identified date in 2018, for resident #005 indicated the resident's continence status. Record review of the written plan of care completed nine days prior to the RAI-MDS assessment for resident #005, indicated that the intervention for resident #005's continence status included strategies to address root causes of their identified continence status. Further review of the plan of care failed to indicate the specific strategies.

In an interview, RN #104 stated three specific continence care strategies provided for resident #005.

In interviews, RPN #105, RN #104 and ADOC #107 stated the three specified continence care strategies for resident #005 did not provide clear direction to staff and others who provided direct care to the resident.

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

Resident #004 was triggered for continence care during stage one of the RQI.

Record review of an identified assessment completed on an identified date in 2018,

for resident #004, indicated the resident's continence status, toileting status and if resident required the use of incontinent products. Record review of the RAI-MDS completed eight days after the identified assessment above, indicated the resident's continence status during the past 14 days prior to the RAI-MDS assessment date. Resident #004's continence status and use of incontinent products differed between the two assessments.

In interviews, PSWs #100 and #106 indicated the same information regarding resident #004's continence status and care as per the identified assessment above.

In an interview, RN #104 stated that registered staff were responsible for completing the identified assessment and RAI-MDS assessments. When the identified assessment and the RAI-MDS assessment were being completed, the registered staff received feedback from PSWs in the type and size of incontinent product the resident was using, and how much assistance the resident required for toileting.

In an interview, ADOC #107 verified that it was a collaborative effort of the interdisciplinary team to complete the assessments and develop the plan of care. The ADOC acknowledged that there had been a lack of collaboration among the interdisciplinary team when resident #004's identified assessment and RAI-MDS assessments were completed in the same month in 2018.

5. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the development and implementation of the plan of care so that the different aspects of care were integrated and were consistent with and complement each other.

Resident #005 was triggered for continence care during stage one of the RQI.

Record review of an identified assessment completed on an identified date in 2018, for resident #005 indicated the resident's continence status and used an identified incontinent product.

In interviews, PSWs #101 and #119 stated resident #005's identified continence status and used two different types of incontinent products during a 24 hr period. PSW #119 further stated that the type and size of the incontinent products were communicated among staff by indicating on the resident's care plan and the

incontinent products logo posted on the inside door of the resident's closet.

On an identified date in 2018, at 0700 hrs, the Inspector and PSW #119 observed the incontinent products logo posted on the inside door of resident #005's closet had not identified the type and size of incontinent products the resident used. At 1530 hrs, the Inspector and ADOC #107 observed the incontinent products logo posted on the inside door of resident #005's closet had not identified the type and size of incontinent products the resident used.

In an interview, ADOC #107 acknowledged that there was a lack of collaboration among the interdisciplinary team in regards to the type and size of incontinent products resident #005 used.

6. The licensee has failed to ensure that the provision of care set out in the plan of care was documented.

On an identified date in 2017, the MOHLTC received a complaint from resident #015's SDM in regards to the resident's specific ADL.

Review of the complaint indicated that resident #015's identified area of the body was unclean and had an identified odour during a visit by the complainant.

The complainant was not available for an interview for the clarification of the date the complainant visited resident #015.

During the course of the inspection, the Inspector observed resident #015 was clean and did not have the identified odour.

Review of the health record of resident #015 indicated that the resident had been admitted to the home on an identified month in 2017. Review of the documentation survey report for the same month, indicated that resident #015 had been scheduled for the identified ADL on two identified days and shift during the week.

In interviews, PSWs #100, #133 and #138 stated resident #015 had been scheduled for the identified ADL on the two identified days and shift noted above, and all PSWs stated they had provided the ADL to resident #015 in the identified month, according to the schedule. After the ADL had been provided to the resident, PSWs had to document on the I-Pad through the home's point of care (POC) program. All PSWs further stated that documentation would have been made if the

resident refused the ADL. Record review of the progress notes for the identified month by the registered staff failed to reveal any entries related to the resident's refusal of the ADL.

Review of the documentation survey report for the identified month for resident #015, indicated two entries had been documented by the PSWs in relation to the resident's identified ADL. The ADL had been provided to resident #015 on an identified day and resident refused the ADL on another identified day in the identified month.

In an interview, DOC #120 acknowledged the identified ADL during the identified month had not been documented as required.

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.

- to ensure that there was a written plan of care for each resident that sets out, clear directions to staff and others who provided direct care to the resident.

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

- to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, 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.

- to ensure that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Findings/Faits saillants :

The licensee failed to ensure that the home approved the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval.

On an identified date in 2018, the MOHLTC received a complaint in regards to applicant #032's approval for admission to the home having been withheld.

Review of the letter sent to the MOHLTC on an identified date in 2018, in regards to the home's decision to withhold the approval of admission for applicant #032 indicated that applicant #032's application had been withheld due to the lack of resource to adequately meet the applicant's care requirements for safety. Further review of the above mentioned letter indicated that the home had reviewed applicant #032's assessments and believed that the applicant would benefit from a behavioural support unit which the home did not have.

In an interview, DOC #120 stated that after reviewing applicant #032's assessments, the team decided not to accept applicant #032's application because the applicant's behaviours may disturb other residents and roommate on the unit. The DOC also stated that applicant #032 would benefit from a behavioural support unit due to the applicant's identified responsive behaviours. The DOC further stated that the home had access to Behaviour Support Ontario (BSO), had a responsive behaviour program in place, and all staff in the home received training in managing residents with responsive behaviours. DOC #120 acknowledged the fact that the home did not have a behavioral support unit was not one of the grounds indicated in the Long Term Homes Act and Regulations for withholding the approval of admission for resident #032.

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 approves the applicant's admission to the home unless, (a) the home lacks the physical facilities necessary to meet the applicant's care requirements; (b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or (c) circumstances exist which are provided for in the regulations as being a ground for withholding approval, to be implemented voluntarily.

WN #5: 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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers or wounds was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #009 was triggered from stage one for altered skin integrity through the

MDS assessment.

Review of resident's MDS assessment on an identified date in 2018, indicated resident #009 had an area of altered skin integrity.

Resident #009 was admitted to the home on an identified date in 2017. Review of the admission note and an identified assessment dated one day after admission, indicated resident had identified areas of altered skin integrity to an area of the body and received treatment. Review of the resident's identified assessments indicated one month after admission, one area of the resident's altered skin integrity worsened and had healed 16 days later. Twenty days later, an identified assessment indicated the resident had multiple areas of altered skin integrity to the same area of the body.

Review of another identified assessments in PCC did not indicate that weekly assessments for the altered skin integrity from admission had been completed until an identified assessment had been completed one month later, when the resident's area of altered skin integrity worsened.

In interviews, RPNs #103 and #110 stated it is the home's expectation for weekly assessments to be completed for altered skin integrity. The RPNs reviewed the assessments for the resident and indicated that weekly assessments had not been completed for the area of altered skin integrity on admission.

Further review of the resident's electronic medication administration (EMAR) records over a period of three months in 2018, inidcated weekly assessments for the area of altered skin integrity had been signed off by RPNs #103 and #110 as completed on seven identified dates. Review of the weekly assessments in PCC for the resident's altered skin integrity did not indicate corresponding assessments on the seven identified dates.

In interviews, RPNs #103 and #110 stated when weekly assessments are signed off by the registered staff on the EMAR, it means that the assessment had been completed. RPN #103 confirmed they had signed off on completing the weekly assessments on five of the identified dates but did not complete the assessments, as they were too busy on the unit. RPN #110 confirmed they had signed off on completing the weekly assessments on two of the identified dates on the EMAR but forgot to complete the assessments. Both RPNs stated they did not follow the home's expectation regarding completion of weekly assessments for resident

#009's altered skin integrity.

In an interview, SWC RPN #118, indicated it is the home's expectation for weekly assessments to be completed to know the progress of the altered skin integrity and to assess if the interventions were working. The SWC RPN reviewed resident #009's EMARs and weekly assessments and did not locate the weekly assessments for the resident's area of altered skin integrity on admission and when the area worsened. The SWC RPN acknowledged the home had failed to complete weekly assessments for resident #009 altered skin integrity as per home's expectation.

In an interview, ADOC #107 indicated it is the home's expectation for weekly assessments to be completed for altered skin integrity. The ADOC reviewed the weekly assessments and progress notes for the resident's area of altered skin integrity on admission and when it worsened and confirmed that weekly assessments had not been completed for resident #009 as per home's expectation.

2. Resident #012 was triggered from stage one for altered skin integrity through the MDS assessment.

Review of resident's MDS assessment on an identified date in 2018, indicated resident #012 had an identified type of altered skin integrity. Record review of the progress notes and identified assessments indicated about one month prior to the completion of the MDS assessment, resident had an identified area of altered skin integrity.

Review of resident's electronic medication administration record (ETAR) for an identified month in 2017, indicated an order for weekly assessment for the altered skin integrity which had been signed off by RPN #149 on an identified day, and RPN #150 on two identified days. Review of the weekly assessments in PCC for the altered skin integrity for resident #012 did not indicate any completed assessments corresponding to the three identified days.

In interviews, RPNs #149 and #150 indicated weekly assessments had to be completed when a resident has altered skin integrity. The RPNs stated when the registered staff signs off on the ETAR for the weekly assessment, it means the assessments had been completed. RPN #150 reviewed the altered skin integrity assessments and progress notes and indicated they had not completed the weekly

assessment for the resident's altered skin integrity on the two identified days. RPN #150 stated they did not recall if they had completed the weekly assessment on the identified day noted.

In an interview, SWC RPN #118, indicated it is the home's expectation for weekly assessments to be completed to know the progress of the altered skin integrity and to assess if the interventions were working. The SWC RPN reviewed resident #012's ETAR for the identified month mentioned above and the resident's weekly assessments for the altered skin integrity and confirmed that weekly assessments had not been completed on the three identified dates mentioned above, as per expectation.

In an interview, ADOC #107 indicated it is the home's expectation for weekly assessments to be completed for altered skin integrity. The ADOC reviewed the weekly assessments and progress notes for the resident's altered skin integrity and confirmed that the weekly assessments had not been completed on the three identified dates mentioned above for resident #012 as per home's expectation.

3. The home submitted a CIS report #2117-000018-17 to the MOHLTC on an identified date in 2017. The CIS report indicated the home received a concern from the SDM of resident #018 regarding resident's skin integrity to identified areas of the body.

Review of the progress notes on an identified date in 2017, indicated that resident #018 had an area of altered skin integrity to an identified area of the body. A progress note eight days later, from the home's physician indicated the status of another area of altered skin integrity and treatment was provided. Both areas of altered skin integrity were close to each other. Seven days later, record review indicated resident #018 had been admitted to hospital for four days on identified dates, and returned to the home. The readmission note from hospital, indicated the altered skin integrity to the identified areas were healed.

Review of the weekly assessments in PCC did not indicate assessments for the resident's altered skin integrity had been completed after discovery on an identified date in 2017.

In interviews, RPNs #105 and #103 stated it is the home's expectation for weekly assessments to be completed for altered skin integrity. RPN #105 reviewed the weekly assessments for resident's altered skin integrity and indicated the

assessments had not been completed after it was discovered, and prior to resident going to hospital in the same month.

In an interview, SWC RPN #118, indicated it is the home's expectation for weekly assessments to be completed to know the progress of the altered skin integrity and to assess if the interventions were working. The SWC RPN reviewed resident #018's weekly assessments for the altered skin integrity and confirmed that the weekly assessments had not been completed after it was discovered, as per home's expectation.

In an interview, ADOC #107 indicated it is the home's expectation for weekly assessments to be completed for altered skin integrity. The ADOC reviewed the weekly assessments for resident #018's altered skin integrity and acknowledged the weekly assessments had not been completed after it was discovered, until resident was transferred to hospital, as per home's expectation.

4. The home submitted a CIS report #2117-000015-17 to the MOHLTC on an identified date in 2017, related to resident #013's area of altered skin integrity.

Record review of the weekly assessment for the altered skin integrity on an identified date in 2017, indicated resident #013 had the altered skin integrity since an identified date in 2014.

Review of the weekly assessments in PCC indicated weekly assessments for the altered skin integrity had not been consistently completed over a seven month period in 2017 and into 2018.

In interviews, RPNs #103 and #110 stated it is the home's expectation for weekly assessments to be completed for altered skin integrity. RPN #103 reviewed the weekly assessments for resident #013's altered skin integrity and indicated the assessments had not been completed consistently.

In an interview, SWC RPN #118 stated it is the home's expectation that weekly assessments to be completed to know the progress of the wound and to assess if the interventions were working. The SWC RPN reviewed resident #013's weekly assessments for the altered skin integrity and confirmed the weekly assessments had not been completed consistently over the identified seven month period as per home's expectation.

In interviews, the ADOC #107 and DOC #120 indicated it is the home's expectation for weekly assessments be completed for altered skin integrity. They both acknowledged that resident #013's weekly assessments for the altered skin integrity had not been completed consistently, as per home's expectation.

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

WN #6: 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 :

The licensee had failed to ensure that drugs are stored in a medication or treatment cart that was secure and locked.

i) During the initial tour of the home, the Inspector observed a treatment cart had been left unsecured and unlocked near a specified area of an identified RHA. The Inspector was able to freely open drawers on the treatment cart that contained medicated treatment creams and dressing supplies.

Observations also indicated two residents seated opposite the identified area with no registered staff having the treatment cart within their line of vision. After approximately four to five minutes RPN #110 had emerged from the closed door of an identified room and quickly came over to the treatment cart where the Inspector had been standing and proceeded to return a treatment cream and locked the cart.

In an interview, RPN #110 stated the treatment cart is to be locked whenever left unattended. RPN #110 further stated that they had just gotten a treatment for a resident in an identified room and was coming right back. RPN #110 verified the treatment cart had not been within their line of vision.

ii) Observations conducted 10 days later at 0816 hrs by the Inspector indicated the medication cart located in the same RHA had been left unattended and unlocked. The Inspector was able to freely open the drawers which contained resident medications.

Observations also indicated one resident was seated directly opposite the medication cart and other residents were observed walking past with no registered staff in site. At approximately 0822 hrs, seven minutes later RN #111 was observed exiting a nearby resident room with inhalant medications in their hand.

In an interview, RN #111 stated the medication cart is to be locked whenever left unattended and that the cart had not been within their line of vision.

In an interview, DOC #120 acknowledged the home's expectation was that when a treatment or medication cart is left unattended it must be secured and locked and agreed the home had failed to ensure the treatment and medication carts that had been left unattended were secured and locked.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance - to ensure that drugs are stored in a medication or treatment cart that is secure and locked, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee failed to ensure there was a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

The nutrition and hydration inspection protocol (IP) was inspector initiated for residents #020 and #021 as a result of missing heights for 2017, during stage one of the RQI.

During stage one of the RQI, census review indicated that the last documented height for residents #020 and #021 had been on identified dates in 2016. Staff interview with RN #104 during stage 1 of the RQI, confirmed that the 2017, heights were not documented for the residents.

In an interview, RN #104 stated it is the home's process for resident heights to be taken annually. The RN stated they had followed up with the DOC and the annual heights for residents #020 and #021 had not been completed as per home's process and had been missed for 2017.

WN #8: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

Related to the mandatory medication IP completed during the RQI, medication incidents and errors were reviewed for resident’s #046, #047 and #048 for the past quarter.

Review of the medication incident report completed for resident #046 indicated during preparation for a collaborative medication review on an identified date in 2018, the pharmacist discovered resident #046 had been experiencing an identified medical condition for eight of the past ten days which had not been communicated to the RN or physician.

Further review of the medication incident report completed indicated that family had not been notified.

In an interview, DOC #120 stated they had not considered the incident to be a medication error or incident and therefore had not informed resident #046’s family.

DOC #120 acknowledged the home had failed to inform resident #046’s family of the medication incident.

Issued on this 1 day of August 2018 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Toronto Service Area Office
5700 Yonge Street, 5th Floor
TORONTO, ON, M2M-4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
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Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JOY IERACI (665) - (A1)

Inspection No. / No de l'inspection : 2018_712665_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 006704-18 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Aug 01, 2018;(A1)

Licensee / Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9

LTC Home / Foyer de SLD : Extendicare Scarborough
3830 Lawrence Avenue East, SCARBOROUGH, ON, M1G-1R6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Pinky Virdi

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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)

Linked to Existing Order / Lien vers ordre existant: 2017_626501_0022, CO #001;

Pursuant to / Aux termes de :

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.

Order / Ordre :

The licensee has failed to comply with compliance order #001 from inspection #2017_626501_0022 served on December 12, 2017, with a compliance date of December 29, 2017 for O. Reg. 79/10, r.36.

The licensee was ordered to ensure all direct care staff received shift report before caring for residents and PSW #109 used safe transferring and positioning techniques when transferring residents.

The licensee shall prepare, submit and implement a plan to ensure staff use safe transferring and positioning devices or techniques when assisting resident #045 and other residents. The plan must include, but is not limited, to the following:

1) PSW #109 receives re-education on safe transferring and positioning techniques and on the use of the proper sling based on the assessment of the resident/s.

2) PSW #109 and all PSWs are educated on the different types of slings and the manufacturer's recommended use for each sling type. The home is required to maintain a documentation record of the education, including the dates education was provided, who provided the education and the content of the education session/s and who attended.

3) All registered staff are educated on the process of how to assess residents for appropriate sling size and type.The home is required to maintain a record of the education, including the dates education was provided, who provided the education and the content of the education session/s and who attended.

4) Develop an on-going auditing process to ensure PSW #109 and all PSWs and registered staff use safe transferring and positioning techniques with residents. The home is required to maintain records of the audits, the dates the audits were conducted, who performed the audits and an evaluation of the results.

Please submit the written plan for achieving compliance for 2018_712665_005 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.MOH@ontario.ca by July 23, 2018.

Grounds / Motifs :

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

The Ministry of Health and Long Term Care (MOHLTC) received a critical incident system report (CIS) #2117-000003-18 on an identified date in 2018, for an incident that occurred four days earlier.

The CIS indicated the MOHLTC had been notified on the day of the incident and the home had been provided with report #18568. The CIS further indicated while being transported in a wheelchair by Personal Support Worker (PSW) #126 from the washroom to their bed resident #014 fell out of the wheelchair sustaining an injury that required a transfer to hospital for an identified treatment.

Review of resident #014's health record indicated they had been admitted to the home on an identified date in 2014. Further review of the health record indicated a decline in resident #014's health status related to an identified medical diagnosis and now required extensive assistance with all transfers by two staff. Review of the written plan of care in Point Click Care (PCC) indicated resident #014 was at an identified risk for falls.

In an interview, PSW #126 stated they had been toileting resident #014 as per normal routine before the resident's identified activity of daily living (ADL). PSW #126 further stated after transferring resident #014 into the wheelchair after toileting, they had not positioned resident #104 properly in the wheelchair. PSW #126 stated they were standing behind the wheelchair when resident #014 began to fall and the PSW attempted to prevent the fall; however, resident #014 fell onto the floor. PSW #126 acknowledged that resident #014 had not been positioned properly in the wheelchair.

In an interview with resident #014, they did not remember the above mentioned fall incident.

Review of PSW #126's personnel file indicated they had received discipline based on their failure to ensure resident safety when transporting the resident, violation of the home's policies and procedures, employee standards of conduct and Resident's Rights. The home also wrote that PSW #126 had neglected to provide a safe

environment and imposed a huge risk to the resident's well-being and care.

In an interview, Director of Care (DOC) #120 who was also the lead for the Falls Prevention program in the home verified that PSW #126 had failed to ensure staff used safe transferring and positioning techniques when assisting resident #014.

2. A follow-up inspection was conducted concurrently with the resident quality inspection (RQI) related to compliance order O. Reg., s. 36, served under inspection number #2017_626501_0022, specific to PSW #109's transferring techniques. As resident #010 no longer resided in the home, observations of PSW #109 conducting resident transfers were expanded to include residents #045 and #044.

Review of resident #045's health record indicated they had been admitted to the home on an identified date in 2018, with underlying health conditions.

Further review indicated resident #045 was dependent for all aspects of positioning, requiring total assistance and transferring with an identified mechanical lift. An identified assessment completed on admission identified the type of sling to be used for transferring the resident.

Review of in-service records for PSW #109 indicated they had received education on transfers, mechanical lifts, received a certificate for safe patient transfer by the home's physiotherapist and importance of shift change on two identified dates in 2017 and 2018.

In an interview, physiotherapist (PT) #129 stated that PSW #109 had demonstrated an understanding of safe patient transfers after receiving education on an identified date in 2017.

On April 23, 2018, observations by the Inspector indicated PSW #109 had used another type of sling on an identified mechanical lift to transfer resident #045 from bed into an identified chair with the assistance of a co-worker. PSW #109 stated resident #045 had been transferred safely with the sling on prior occasions. Further observations indicated resident #045's body and identified extremities were in an identified way and the two PSWs experienced some difficulty maneuvering resident #045's identified area of the body around the mechanical lift and into the identified chair.

During a conversation with resident #045 they stated during the above mentioned transfer an identified area of the body was sore as it felt like it had not been supported.

Review of the manufacturer's recommendations, for use of the identified sling used in the transfer with PSW #109 above, indicated that the sling had been specifically designed to be used from a sitting position with either a patient lift or a stand aid. The recommendations further indicated this sling had been specifically designed for toileting and hygiene functions.

Review of the identified assessment completed on admission by registered nurse (RN) #123 indicated resident #045 had been assessed to be transferred with an identified sling, different from the identified sling used by PSW #109 noted above. RN #123 could not recall receiving training on how to assess a resident for proper sling size and type however, they assess a resident visually, by following the identified assessment tool and at times will also take the transferring care needs from the resident's RAI-MDS admission package.

In an interview, PT #129 stated the identified sling used by PSW #109 was not an appropriate sling for resident #045 due to their identified functional abilities and that the identified sling noted in the identified assessment by RN #123 should have been used for all transfers.

In an interview, DOC #120 verified that PSW #109 had not used safe transferring and positioning devices or techniques when assisting resident #045.

The severity of this issue was determined to be a level three as there was actual harm to residents #045 and #014. The scope of the issue was a level two as there was a pattern of the residents who were reviewed. The home had a level four compliance history, Compliance Order continues with original area of non compliance in the last 36 months as follows:
1) 2017_626501_0022 RQI - Compliance Order #001
2) 2016_302600_0021 CIS - Compliance Order #001
(589)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Oct 09, 2018

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

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.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 9 (1) and r. 9 (1) 2.

The licensee shall prepare, submit and implement a plan to ensure that all doors leading to stairways are kept closed and locked and ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff. The plan must include, but is not limited, to the following:

1) The implementation of measures to supervise the north and south basement stairwell doors until locks are installed.

2) The development of on-going auditing process to ensure doors that lead to non-residential areas/storage rooms in the home are kept secured and locked at all times when unsupervised. The home is required to maintain a record of the audits, the dates the audits are conducted, who performed the audits and an evaluation of the results.

Please submit the written plan of achieving compliance for 2018_712665_0005 to Joy Ieraci, LTC Homes Inspector, MOHLTC, by email to TorontoSAO.MOH@ontario.ca by July 23, 2018.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that all doors leading to stairways are kept closed and locked.

On April 10, 2018, observations conducted by the Inspector during the initial tour of the home indicated the basement's north and south stairwell doors were unlocked and unsupervised. The south stairwell had two flights of stairs that led to a locked kitchen door and the north stairwell had stairs that led to the first and second floors of the home, as well as to a locked door that lead to the home's back garden. Further observations revealed the basement had resident spaces that included the program room, the offices of the Social Worker (SW) and Program Manager (PM) and directly to the right of the elevator doors, there were three bookshelves that consisted of a resident library.

In an interview, PSW #142 acknowledged on April 22, 2018, at approximately 2345 hrs they had heard the stairwell door closing and when they looked down the first floor hallway, they observed resident #043 had exited the stairwell door and then

proceeded to walk into the main floor dining room.

On April 23, 2018, observations were conducted by the Inspector related to compliance order follow-up inspection #2017_626501_0022; where the home had been ordered to ensure all staff attend morning shift report prior to giving care to residents. During this observation, RN #132 indicated resident #043 had been observed exiting the north stairwell door on the first floor at approximately 2345 hrs by a PSW working on the first floor.

The shift report also indicated they were uncertain how resident #043 had gained access to the stairwell; however, they assumed resident #043 had accessed the north stairwell from the basement as the resident knew the elevator code and took the stairs to the first floor. Review of resident #043's progress notes indicated that resident #043 had been observed walking through the dining room before entering the elevators and returned to the second floor.

In an interview, PSW #142 acknowledged on April 22, 2018, at approximately 2345 hrs they had heard the stairwell door closing and when they looked down the first floor hallway, they had observed resident #043 had exited the stairwell door and then proceeded to walk into the main floor dining room.

In an interview, Administrator #126 stated that residents would require the elevator access code to get to the basement and that residents were not aware of the elevator access code.

Inspector conducted an interview with resident #043 with the assistance of Inspector #726 to interpret because of a language barrier. During the interview, resident #043 had not answered the questions appropriately; therefore, the interview was ended.

Review of resident #043's health record indicated a cognitive assessment had been completed on January 31, 2018, which indicated a cognitive performance scale (CPS) of one indicating a borderline intact and short term memory. The assessment also indicated resident #043 had been aware of the current season, location of their room, staff names/faces and that they were in a facility and their decision making skills were modified independence-some difficulty in new situations only. The assessment also indicated there had been no change in resident #043's cognitive status over the past 90 days. Further review of resident #043's plan of care in place at the time of this inspection revealed the following:

- has right spastic hemiplegia with loss of range of motion (ROM)
- at moderate risk for falls
- is aphasic due to a stroke
- is independent with locomotion on and off the unit but will require supervision and staff assistance at times
- remind resident and redirect if noted making attempts to use the stairs.

Review of resident #043's progress notes revealed the following:
- on December 7, 2017, resident #043 had a fall with no injuries in the stairwell and at that time the home changed the stairwell door codes
- on February 10, 2018, resident #043 had come down to the basement alone and had asked program aide #130 to assist with getting clothing from the laundry
- on March 11, 2018, at 2415 hrs, RN #132 stated they heard knocking coming from the north stairwell door on the second floor and when they opened the door resident #043 was standing there smiling.

Video surveillance from the basement dated April 22, 2018, indicated resident #043 had been walking in the basement hallway at approximately 2325:07 hrs alone. The video surveillance further revealed resident #043 had knocked on the laundry room door at 2325:24 hrs and when not answered they proceeded in the hallway towards the north stairwell doors at 2325:42 hrs.

In an interview, PSW #136 had recalled that on one occasion resident #043 went on the elevator at the same time as them and proceeded to enter the basement access code on the elevator keypad unassisted. PSW #136 further stated they both went to the laundry room. PSW #136 could not recall the actual date but only that it had occurred this year. PSW #136 further stated resident #043 would routinely take down their own laundry unassisted.

In an interview, PT #129 stated that due to resident #043's hemiplegia from a stroke, an unsteady gait and risk for falls, they were not to access the stairs.

In an interview, Administrator #126 verified the licensee had failed to ensure that all doors leading to stairways were locked when not being supervised by staff.

The severity of this issue was determined to be a level two as there was potential for actual harm. The scope of the issue was a level one as it was isolated to the residents reviewed. The home had a level four history as they had on-

going non-compliance with this section of the LTCHA that included:
1) 2017_626501_0022 RQI - VPC was issued
2) 2015_377502_0017 RQI - VPC was issued
(589)

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

Sep 28, 2018

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

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

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

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 1 day of August 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JOY IERACI - (A1)

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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

Service Area Office / Bureau régional de services : Toronto