

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
soins de longue durée
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 24, 2020	2020_853692_0001	012240-20, 014245- 20, 014641-20, 015021-20, 015096-20	Complaint

Licensee/Titulaire de permisExtendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9**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**SHANNON RUSSELL (692), JENNIFER BROWN (647), JENNIFER LAURICELLA (542),
LISA MOORE (613)**Inspection Summary/Résumé de l'inspection**

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 14-18, 2020.

The following intake(s) were inspected upon during this Complaint Inspection:

-One log, which was related to a complaint that was submitted to the Director regarding concerns with residents receiving nourishment and weight loss;

-One log, which was related to a complaint that was submitted to the Director regarding a resident not receiving their medication as per ordered;

-One log, which was related to a complaint that was submitted to the director related to a fall of a resident resulting in a transfer to the hospital; and,

-Two logs, which were related to complaints that were submitted to the Director regarding the physician not being on-site at the home during the COVID-19 outbreak.

A Critical Incident System Inspection #2020_853692_0002 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Interim Administrator, Director of Care (DOC), Pharmacist, Registered Dietitian (RD), Support Services Manager, Extendicare Long-Term Care (LTC) Consultants, Housekeeper, Infection Prevention and Control (IPAC) Lead, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident and resident to resident interactions, reviewed relevant health care records, the home's complaint log, internal investigation notes, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

**Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services**

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

5 WN(s)

5 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents, specifically related to the home's floor cleaning process.

A complaint was submitted to the Director regarding a resident that had fallen, sustaining an injury, as a result of the flooring being wet.

The residents care plan identified that they were a high risk for falls, and were able to ambulate independently. The home's investigation file identified that the floor had been mopped while the resident was present in the room, which resulted in the resident slipping on the wet flooring and sustaining an injury.

During the current inspection Inspector #542 observed a resident sitting in a chair, and their flooring was wet. The resident's care plan indicated that they could ambulate independently. The housekeeping staff indicated that the resident needed to be supervised as the flooring was wet and the resident would attempt to ambulate.

The Director of Care (DOC) and the Support Services Manager stated that the fall was the home's error as the housekeeping staff had mopped the flooring while the resident was still present in the room. They both indicated that since that incident, the home had changed their process with the mopping of the resident's rooms. They would no longer be mopping the floors when an ambulatory resident was still in their rooms without a staff members supervision.

Sources: LTCH's investigation notes; residents' care plan and progress notes; interviews with the DOC, and other staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home is a safe and secure environment for its residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any policy instituted or otherwise put in place was complied with.

According to the Ontario Regulation (O. Reg.) 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Specifically, staff did not comply with the home's policy and procedure "Missing Signatures".

During a medication review, the electronic Medication Administration Record (eMAR) for a resident were missing four signatures for both of the two months reviewed.

The policy indicated that missing signatures would be considered a medication incident.

The Extendicare Long-Term Care (LTC) Consultant was requested to provide all the medication incident reports for the period reviewed; they indicated the home had not completed medication incident reports for this period, as the policy had indicated.

Sources: eMAR records, "Medication Incident and Reporting" policy, "Missing Signature" policy, progress notes, interviews with Extendicare LTC Consultant, and other staff. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that where the Act or this Regulation requires the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of health conditions, including any risk of falls and interventions to mitigate those risks.

During the inspection the Inspector observed a resident sitting in a chair, with the surrounding floor wet, as it had just been mopped. The Inspector waited for approximately two - four minutes and had not observed any staff members watching the resident to ensure they did not attempt to ambulate, and potentially slip on the wet flooring.

A review of the resident's care plan was completed, which did not include their risk of falls or any interventions to prevent falls.

During separate interviews with the Physiotherapist (PT), Registered Nurse (RN) and Extendicare LTC Consultant, they all indicated that the care plan for the resident was to contain a Focus heading for Fall Prevention, as the resident had sustained previous falls.

Sources: Observations, the residents care plan, interviews with PT, and other staff. [542] [s. 24. (2) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the residents 24-hour admission plan of care is based on, at a minimum, interdisciplinary assessment of health conditions, including any risk of falls and interventions to mitigate those risks, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Inspector requested to review the last two quarterly meetings where the effectiveness of the medication management system was evaluated.

The Extencicare LTC Consultant indicated they had not been completed.

Sources: Medication Management System documents, interviews with Extencicare LTC Consultant, and other staff. [s. 115. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the quarterly evaluation for the medication management system program is completed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Director received a complaint that indicated a resident had not received a medication as specified by the prescriber.

The resident was prescribed a specified medication, in which they were to receive a specific dose at indicated times daily.

The Pharmacist indicated to the Inspector that the container for the medication had a specific number of doses and was to last a specified number of days. When they reviewed the ordering history of the medication, it identified the number of days between ordering would exceed the days of medication in one container; therefore, the resident had not received their medication as prescribed.

Sources: Complaint, eMARs, progress notes and care plan for a resident, and interviews with Pharmacist and other staff. [s. 131. (2)]

Additional Required Actions:

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

Issued on this 25th day of September, 2020

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

Original report signed by the inspector.