Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2013	2013_196157_0031	001169-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE TORONTO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE GUILDWOOD
60 GUILDWOOD PARKWAY, SCARBOROUGH, ON, M1E-1N9

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

PATRICIA POWERS (157), CHANTAL LAFRENIERE (194)

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): December 18, 2013

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Physiotherapy Assistant (PTA), 5 Personal Support Workers (PSW), 2 Registered Practical Nurses (RPN), Clinical Coordinator, RAI Coordinator, Maintenance, 1 Registered Nurse (RN), Resident #01.

During the course of the inspection, the inspector(s) reviewed the clinical health record of an identified resident, reviewed Critical Incident Reports, internal incident reports, facility policies and procedures related to pain management, safe lifting, equipment tag out/lock out procedures and resident abuse, observed staff:resident interactions, observed provision of resident care, toured the west unit, observed bathing/shower facilities and care/transferring equipment

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 s. 6(1)(c) when the plan of care for resident #01 did not provide clear directions for the staff and others who provide direct care to the resident:

On an identified date, resident #01 was involved in an incident resulting in an injury. On an identified date, the resident was diagnosed with an injury requiring medical intervention.

Resident #01's plan of care directs that the resident requires the assistance of one staff member for showering and two staff members and a mechanical lifting device for transfers.
The DOC confirmed that resident #01's plan of care is inaccurate, stating that the resident does require the assistance of two staff members for transfers and showering. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA, 2007 s. 6(7) when the care set out in the plan for resident #01 was not provided as specified in the plan.
The plan of care for resident #01 indicates that the resident is to use an identified therapeutic mattress for alternating pressure.
- The Clinical Coordinator confirmed and the inspectors observed that the resident was not using the specified mattress on an identified date. [s. 6. (7)]

3. The licensee failed to comply with LTCHA, 2007 s. 6(8) when staff and others who provide direct care to a resident did not have access to the most current plan of care.
- The RAI Coordinator advised that residents' Plans of Care are available to staff who provide direct care to residents in a binder at the nurses station. She advised that the plan of care accessible to staff is not always the most current.
The electronic plan of care for resident #01 provides direction related to the use of an identified therapeutic mattress and the resident's need for repositioning which is not provided on the plan of care available to PSW's.[s.6.(8)]

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 written plan of care for resident #01;
- sets out clear direction to staff and others who provide direct care to the resident
- that the care set out in the plan is provided as specified in the plan
- staff and others who provide direct care to a resident have access to the most current plan of care, to be implemented voluntarily.

WN #2: 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 failed to comply with O.Reg 79/10, s.36 when staff failed to use safe transferring and positioning techniques when assisting resident #01.

Licensee policy "Safe Lifting with Care Program" - Section "Mechanical Lifts" #01-01 (undated) directs that staff are to "Check the care plan for the approved Mechanical Lift transfer process for the resident each shift as the resident's status will change"; The "Safe Resident Handling Procedure" directs that "All mechanical lifts require two caregivers to operate."

The plan of care for resident #01 directs that 2 staff are to provide physical assistance with a mechanical lifting device.

The DOC, Registered Nurse and PSW confirmed that on an identified date, resident #01 was transferred with a mechanical lift by one staff member, resulting in the resident being injured. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg s.52(1)3. when comfort measures for resident #01 were not identified or put in place.
The plan of care for resident #01 for pain management directs staff to "Provide alternative comfort measures like repositioning." On an identified date the resident was observed to be lying on the bed with no sheets, with a blanket partially covering the mattress. The resident was wearing a soiled, thin hospital like gown. Staff advised that the resident was on full bed rest. The plan of care failed to provide clear direction for staff related to increased care needs related to comfort. [s. 52. (1) 3.]

2. The licensee failed to comply with O.Reg s.52(2) when resident #01's pain was not relieved by initial interventions and assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The home's policy "Pain Management", Policy #RESI-10-03-01, dated November 2013 was not complied with by staff.
The licensee's policy directs the following;
- A pain assessment will be completed with a change in condition
- Care staff to screen each shift for pain during the seven day look back period for all residents on regularly scheduled pain medication to assess the effectiveness prior to assessment reference date (ARD) for completion of RAI MDS.

The DOC confirmed that the home's "pain assessment" process was the tool provided on the Point Click Care System (PCC).
- Resident #01 is administered routine medication for pain management and has a medication ordered for use as needed (PRN) for transfers or showers. There is no clear direction in the plan of care for resident #01 related to the appropriate use of the PRN analgesic medication.

- On an identified date resident #01 was involved in an incident resulting in an injury.
- A pain assessment was completed for the resident,indicating there was pain. The assessment states that any movement or touching of the area causes pain and identifies that the pain is continuous and more extreme than previously identified.
- On an identified date the resident was further assessed in hospital and treated for an injury. No pain assessment in PCC was completed.

The progress notes for resident #01 indicate:
- the resident was indicate pain on four identified dates and no PCC assessment was completed.
- On an identified date the resident indicated pain. No interventions were noted to have been provided.

- Staff member interviewed stated that resident #01 is always in pain when she cares for the resident.
- Interview with registered nursing staff member indicated that the staff member feels that the pain medication is effective but that assessment of resident #01 is difficult related to communication barriers.

The resident's clinical health record indicates that the routine doses of analgesics were not effectively managing resident #01's pain. There were no clinically appropriate pain assessments completed for this resident. [s. 52. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the pain management program for resident #01 provides comfort care measures and to ensure that when resident #01's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.26(3)10 when the plan of care for resident #01 related to pain was not completed with an interdisciplinary assessment related to the resident's current health conditions.

- Resident #01 has physician's orders for pain management interventions.
- A pain assessment was completed for resident #01 on an identified date indicating that the resident was experiencing pain. No further pain assessments have been completed.
- Resident #01 was assessed by the Registered Physiotherapist on an identified date. The assessment indicated that the resident was experiencing pain. On an identified date a physiotherapist assessment of resident #01 states that the resident has minimal to no pain. On an identified date the Physiotherapist identified the need for additional equipment for resident #01 and directed that the resident was to stay in bed until the equipment was available. The physiotherapy assessment does not provide alternatives for management of pain or recognize ongoing pain experienced by resident #01.

Resident #01 was at high risk for increased pain and/or complications related to current health conditions. Communication barriers made it difficult for staff to accurately assess the resident's pain and comfort. There is evidence in the resident's progress notes that the resident was experiencing breakthrough pain prior to the routinely scheduled administration of analgesics. Pain monitoring was not enhanced as a result of the resident's recent change in condition. [s. 26. (3) 10.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 39. Every licensee of a long-term care home shall ensure that mobility devices, including wheelchairs, walkers and canes, are available at all times to residents who require them on a short-term basis. O. Reg. 79/10, s. 39.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.39 when a mobility device to facilitate the mobility of resident #01 was not available.

On an identified date resident #01 was involved in an incident resulting in an injury.
- On a identified date, progress notes indicate the resident's injury was becoming worse and further assessment was required. The outcome of the assessment resulted in a physiotherapy assessment indicating that the resident was to stay in bed until required equipment for the resident was obtained.
- On an identified date the resident was observed to be in bed. Clinical Coordinator confirmed that the resident was on complete bed rest. The Physiotherapy Assistant confirmed that the required equipment had not been received and as a result resident had remained in bed.
- There is no evidence that alternatives were considered until the appropriate equipment was available. [s. 39.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s.43 when strategies were not developed and implemented to meet the needs of resident #01 who was unable to communicate related to compromised communication and verbalization skills and inability to communicate in the language used in the home.
- Resident #01 has physical and language barriers to communication.
- Inspectors observed resident's communication abilities and it appeared that the resident was not able to understand inquiries related to pain or comfort. The resident's spoken words were not understood by the inspector or the staff member present.
- PSW staff , Registered Nursing staff and Physiotherapy Assistant confirmed that communication with the resident was difficult and there were no communication techniques or guidelines provided to support the resident's communication needs.
The plan of care for the resident identifies impaired communication and directs that staff are to follow routine care to ensure that the resident's needs are met, and anticipate the resident's needs and meet them.
The plan of care fails to provide direction related to verbal and non verbal methods of communication for this resident to identify the resident's needs and preferences.
- MDS Assessment for resident #01 inaccurately describes the resident's communication abilities to understand and be understood.

Staff interviewed were not able to provide any planned interventions or consistent protocols, tools or methods for communicating with resident #01. Staff reported that it is difficult to communicate and the resident is assessed using facial and body movement stating "it is more of a visual assessment." [s. 43.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 90.(2)(a) when mechanical lifts were not kept in good repair and maintained in accordance with facility policy.
The Licensee policy "Safe Lifting with Care Program" - Mechanical Lifts - #01-01 - directs the following:
- "All mechanical lifts assigned for a specific unit/floor are available for staff use."
- "Follow Tag Out Procedures for any lift deficiency or breakdown."
- "Remove all equipment from service when deficiencies are identified and follow Tag Out procedures for Mechanical Lift"

On an identified date the following was noted by the inspectors and reported by staff:
- Staff member interviewed and reported that two lifts in the shower room are old and have not been in use for some time. There was no "lock/out tag/out" warning tag provided as required by licensee policy "Lockout Policy" - Occupational Health and Safety, Section 4 (undated), to warn employees of an existing or potential hazard.
- 2 staff members interviewed reported that there are a further 3 lifts that are not working on the west unit (one lift on one wing and two lifts on the other wing). One of the identified lifts has a "red tag" attached to the top of the lift, as a warning of a potential hazard and indicating that it is not in use. The other 2 lifts do not have "red tags" attached to them.
The staff members interviewed were unsure of how long these lifts have been broken and unavailable for use. [s. 90. (2) (a)]

Issued on this 3rd day of January, 2014

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

Pat Rum #157 Chantal Lafleur (194)