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

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
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 6, 2017	2016_302600_0021	034706-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE SCARBOROUGH
3830 LAWRENCE AVENUE EAST SCARBOROUGH ON M1G 1R6

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

GORDANA KRSTEVSKA (600)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 20, 2016.

During the course of the inspection, the critical incident log #034706-16, was inspected related to Prevention of Abuse, Neglect and Retaliation and Falls Prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DOC), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapist (PT), housekeeping staff, and Substitute Decision Maker (SDM).

During the course of the inspection the inspector conducted observation of a shower room, staff to resident interaction, review of the critical incident report log, clinical health records, resident's administration file, activity participation records, pain management, staff training record and related home policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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 the staff used safe transferring and positioning devices or techniques when assisted resident #001.

Review of a critical incident (CI) report, submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that on an identified date, PSW#100 turned his/her back

on the resident to reach some resident’s items. The resident then had an incident. After the incident, the resident's condition changed. The physician and the family were notified. The resident was ordered palliative care and was provided with comfort care in the home. Later on the same day, resident #001 passed away. The coroner came, reviewed the resident’s information, and completed the Medical Certificate of Death.

Review of resident #001’s progress notes from two identified dates indicated that the resident's condition was deteriorating after the incident. The physician was contacted and he/she ordered comfort measures that had been followed. The substitute decision maker (SDM) required the staff to provide comfort care. Further the progress notes review revealed the resident deceased later that date. Further review of resident #001’s plan of care including the post incident assessments, failed to reveal how the incident happened.

Review of the most recent minimum data set (MDS) assessment from an identified date, revealed resident #001 required a specified level of assistance from the staff for some of the activities of daily living (ADLs)). Further review revealed the physiotherapist (PT)’s assessment from the same period revealed that the resident had some limitation of an identified extremity.

Review of the resident's written plan of care revealed that resident #001 needed assistance for an identified activity due to generalized limitation. The goal set for that activity was to improve the limitation and to prevent further decline. Resident #001 required specific assistance by staff to provide specified support with process of assisting with the identified activity. Further review of resident #001’s written plan of care revealed the resident had impaired ability related to aging process and some medical conditions. The goal for this focus was for the resident to maintain his/her ability by using assisting devices and staff’s identified assistance.

Interview with the physiotherapy staff #104 confirmed resident #001 needed an identified assistance by staff for an identified activity and the resident to participate in exercises due to the limitations.

Interview with PSW #100 revealed that on an identified date he/she provided assistance to resident #001 with an identified activity. After the PSW completed the activity, he/she wheeled the resident on the equipment to another area. After completing the activity, the PSW asked resident #001 to stand up and hold on to the bar on the wall in front of the resident. The resident stood up. The PSW then turned around to remove the equipment from behind the resident and then reached for the assisting device from the other side to

bring the device behind the resident at which time, the resident had an incident. The PSW stated from the corner of his/her eye he/she saw the resident having the incident. Further, the PSW indicated he/she grabbed the resident's waist and somehow placed the resident on the assisting device. After the incident, the PSW notified the registered practical nurse (RPN) #101.

Interview with PSW #105 confirmed resident #001 needed assistance from staff for identified activity and that was written in the resident's plan of care. Further, he/she confirmed he/she always used the identified assistance for the identified activities by asking the resident to stand up and hold on to the bar. PSW indicated he/she did not provide specified support to the resident during that assistance.

The second interview with the PSW #100 confirmed resident #001 needed a specified support during the assistance by staff for an identified activity. Further the PSW confirmed he/she did not assist with the activity properly as he/she had been doing before when he/she assisted the resident with the activity from the equipment to the assisting device. He/she also acknowledged he/she should not leave resident #001 to stand alone holding on to the bar while he/she perform other activities turning away from the resident.

The scope of the non-compliance is isolated to resident #001. The severity of the non-compliance is actual harm and therefore a compliance order is warranted. There is no previous non-compliance related to O. Reg. 79/10, s. 36. [s. 36.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

Issued on this 9th day of February, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	GORDANA KRSTEVSKA (600)
Inspection No. / No de l'inspection :	2016_302600_0021
Log No. / Registre no:	034706-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 6, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
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

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 shall prepare, submit and implement a plan to ensure that staff use safe transferring and positioning devices or techniques when assisting residents with transfers.
The plan shall include:
- Education of all nursing staff to understand the definition of each level of assistance provided to perform activities of daily living as outlined in the Resident Assessment Instrument Minimium Data Set and how to provide each level of assistance.
- Development and implementation of a system of ongoing monitoring to ensure that the staff use safe transferring and positioning devices or techniques when assisting residents with transfers.

This corrective action plan is to be submitted via email to: Gordana.Krstevska@ontario.ca by February 20, 2017.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the staff used safe transferring and positioning devices or techniques when assisted resident #001.

Review of a critical incident (CI) report, submitted to the Ministry of Health and Long Term Care (MOHLTC) revealed that on an identified date, PSW #100 turned his/her back on the resident to reach some resident's items. The resident then had an incident. After the incident, the resident's condition changed. The physician and the family were notified. The resident was ordered palliative care and was provided with comfort care in the home. Later on the same day, resident #001 passed away. The coroner came, reviewed the resident's information, and completed the Medical Certificate of Death.

Review of resident #001's progress notes from two identified dates indicated that the resident's condition was deteriorating after the incident. The physician was contacted and he/she ordered comfort measures that had been followed. The substitute decision maker (SDM) required the staff to provide comfort care. Further the progress notes review revealed the resident deceased later that date. Further review of resident #001's plan of care including the post incident assessments, failed to reveal how the incident happened.

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Review of the resident's written plan of care revealed that resident #001 needed assistance for an identified activity due to generalized limitation. The goal set for that activity was to improve the limitation and to prevent further decline. Resident #001 required specific assistance by staff to provide specified support with process of assisting with the identified activity. Further review of resident #001's written plan of care revealed the resident had impaired ability related to aging process and some medical conditions. The goal for this focus was for the resident to maintain his/her ability by using assisting devices and staff's identified assistance.

Interview with the physiotherapy staff #104 confirmed resident #001 needed an identified assistance by staff for an identified activity and the resident to participate in exercises due to the limitations.

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resident on the assisting device. After the incident, the PSW notified the registered practical nurse (RPN) #101.

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The scope of the non-compliance is isolated to resident #001. The severity of the non-compliance is actual harm and therefore a compliance order is warranted. There is no previous non-compliance related to O. Reg. 79/10, s. 36. [s. 36.] (600)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 14, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail 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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 6th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Gordana Krstevska

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