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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2018	2018_630589_0013	024350-18, 024358-18	Follow up

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

JOANNE ZAHUR (589)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): November 15, 16 and 19, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Registered staff (RN/RPN), Personal Support Workers (PSW), Housekeeping aides (HA), Director of Resident Programs (DRP), and Residents.

The following Inspection Protocols were used during this inspection:

Personal Support Services
Responsive Behaviours
Safe and Secure Home

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

- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 36.	CO #001	2018_712665_0005	589
O.Reg 79/10 s. 9. (1)	CO #002	2018_712665_0005	589

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	Légende 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).

Findings/Faits saillants :

1. The licensee has failed to ensure the written plan of care set out clear directions to staff and others who provide direct care to resident #004.

A follow-up inspection related to compliance order (CO) #001 under O. Reg. 79/10, r. 36 was conducted during this inspection. The scope of this inspection was expanded to include resident #004 as resident #014 who had been identified in the compliance order no longer resides in the home.

A review of resident #004's most current health record and kardex indicated the use of an identified mechanical lift for transfers. A review of the transfer logo located on the inside of resident #004's closet door indicated the use of an alternate mechanical lift with the use of an assistive device for transfers.

Observations by the inspector indicated staff #105 with the assistance of a co-worker used the identified mechanical lift to transfer resident #004. Staff #105 further stated they had always used this identified mechanical lift for resident #004's transfers.

In an interview, staff #105 acknowledged resident #004's plan of care did not provide clear direction to them related to transferring needs required by this resident.

In an interview, staff #101 acknowledged resident #004's plan of care had not set out clear directions to staff and others who provide direct care to resident #004. [s. 6. (1) (c)]

2. The licensee has failed to ensure the care set out in the plan of care was provided to

the resident as specified in the plan.

While in the home conducting a follow-up inspection related to compliance order (CO) #001 under O. Reg. 79/10, r. 36, staff #113 was interviewed by the inspector. At approximately 1400 hours, the inspector was attempting to locate staff #113 and was informed by staff #104 that they should be with resident #003 as they were on an identified staffing assignment with this resident.

Observations conducted by the inspector at approximately 1405 hours indicated resident #003 was seated in the west lounge unattended and surrounded by multiple residents seated in their wheelchairs. Also, staff #104 could not locate staff #113 at this time.

A review of resident #003's most recent care plan indicated there had been an identified staffing assignment in place for an identified period of time related to responsive behaviours exhibited by them.

At approximately 1415 hours staff #113 was observed exiting the elevators and upon initiating conversation indicated they had gone on break and that staff #109 had offered to provide coverage for resident #003.

Further observations indicated staff #109 had been providing afternoon nourishment to residents located on the east side of the resident home area (RHA) and did not have resident #003 within their line of vision.

In an interview, staff #116, who is also the home's internal behavioral support nurse (BSO) stated this identified staffing assignment required the staff member to remain with the resident and to maintain the resident within their line of vision.

In an interview, staff #109 acknowledged they were supposed to be covering the assignment however when resident #003 had been provided a nourishment they had not been exhibiting any responsive behaviors so they continued with the nourishment cart task which had been initiated at approximately 1400 hours. When staff #109 was asked by the inspector if they had maintained resident #003 within their line of vision, they did not answer the inspector's question, and only continued to state they had not been exhibiting any responsive behaviours.

In an interview, staff #101 acknowledged the home had failed to ensure the care set out in the plan of care had been provided to resident #003 as specified in their plan. [s. 6.

(7)]

3. This inspection included resident #045 as they had been identified in compliance order #001 under O. Reg. 79/10, r. 36.

A review of resident #045's most recent health record indicated the use of an identified lift using an assistive device with two staff.

In an interview, staff #114 indicated they use an alternate assistive device with two staff present when transferring resident #045 to bed in the evening when unable to position the care planned assistive device properly in the wheelchair underneath them. Staff #114 acknowledged the most recent care plan and kardex indicated the use of an identified assistive device with a mechanical lift for all transfers.

A review of education records indicated a representative from the home's equipment supplier had provided an all-day education session from 0800 to 1600 hours on mechanical lifts and assistive transfer devices to PSWs including staff #114.
A further review of education records indicated a video had been presented related to assistive transfer devices: Universal and Comfort Care, to PSWs including staff #114.
Staff #114 verified they had attended the two above mentioned education sessions and had understood the material presented.

As a result of staff #114 acknowledging they used an alternate assistive aid to transfer resident #045, the long term care home (LTCH) provided re-instruction on three identified dates in November 2018, to PSWs including staff #114.

In an interview, staff #101 acknowledged PSW #114 had failed to ensure the care set out in the plan of care had been provided to resident #045 as specified in their plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the plan of care sets out clear directions to staff and others who provide direct care to residents and to ensure the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

Issued on this 29th day of November, 2018

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

Original report signed by the inspector.