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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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2016;	2016_282543_0021 (A1)	000304-16, 012332-16, 014523-16, 017112-16, 018644-16	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 FALCONBRIDGE
281 FALCONBRIDGE ROAD SUDBURY ON P3A 5K4

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Extension requested for compliance orders #001 and #002 received, and approved.

Issued on this 13 day of October 2016 (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

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

TIFFANY BOUCHER (543) - (A1)

Amended Inspection Summary/Résumé de l’inspection modifié

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

This inspection was conducted on the following date(s): June 22-24, June 27-30 and July 4, 2016.

This Critical Incident Inspection is related to five critical incidents; 000304-16 related to alleged staff to resident abuse, 012332-16 related to falls, 014523-16 related to missing medication, 017112-16 related to a resident eloping from the home and 018644-16 related to an unexpected death.

A Complaint Inspection # 2016_282543_0022 was conducted concurrently with this inspection.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, staffing schedules, staff training records, policies, procedures, programs, and staff personnel files.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Assistant Director (s) of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs, Personal Support Workers (PSW), Registered Dietician (RD), Dietary Manager, Restorative Care Manager/Kinesiologist and residents and family members.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Medication

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

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

3 WN(s)
1 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that sets out:
a) the planned care for the resident;
b) the goals the care was intended to achieve; and
c) clear directions to staff and others who provided direct care to the resident.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in June, 2016, regarding the elopement of resident #007. The CI report indicated that the resident was last seen on a day in June, 2016, and then was found the next day by the police.

The Inspector reviewed the resident's health care record which indicated that in June, 2016, a care conference was held with the resident to discuss the elopement. Interventions were discussed and planned with the resident to ensure their safety.

During an interview with Inspector #575, ADOC #106 stated that the resident was

capable of making their own decisions. ADOC #106 stated that when the resident left the home, the staff recorded their absence on the 24 hour report and would sign the resident back in upon their return. In addition, the DOC stated that the resident had left the home to run errands and therefore the resident now has a cell phone that they were to carry with them and they were to also verbally report to a staff member either on the floor or in the office, where they were going and what time they would be back. This was to be recorded by the office staff.

Inspector #575 reviewed the resident's care plan and noted that it had not included the interventions as discussed in the resident's care conference and had not included interventions related to elopement.

During an interview with ADOC #106, they stated to the inspector that the interventions related to ensuring the safety of resident #007 should have been written in the resident's care plan. The ADOC #106 reviewed the resident's care plan and verified it had not been included in the care plan. [s. 6. (1)]

2. 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 different aspects of care were integrated and were consistent with and complemented each other.

Inspector #575 reviewed a report submitted to the Director's After Hour Pager in June 2016, regarding the sudden death of resident #001. The report indicated that, resident #001 was being assisted with their meal when they choked. When the Registered Nurse (RN) attended, the resident was blue.

The Critical Incident submitted to the Director in June 2016, indicated that during the meal service, resident #001 was observed choking and vomiting. Despite interventions implemented by staff, the resident passed away.

A review of the resident's health care records was conducted by the Inspector. The resident was admitted in March, 2016. A 'Nutrition - Registered Dietitian Assessment' was completed in April, 2016, that indicated the type of diet the resident was ordered. It was documented that the resident had swallowing difficulty. The 'Nutrition- Priority Screen' completed in April, 2016, indicated that the resident was at nutritional risk.

A progress note from April 2016, indicated that the RPN had requested the RN to

assess the resident because it appeared that the resident had aspirated on their own vomit.

On a day in April 2016, a referral was made to the Registered Dietitian (RD) indicating that the resident often coughed.The referral indicated that the resident was trialled a certain textured diet.

Another progress note from April 2016, written by the RD indicated the previously ordered texture of diet trialled was successful and there had been no documentation of swallowing or coughing problems.

A progress note from May 2016, indicated that the resident had a large bout of emesis and staff were unsure if the resident had aspirated. The resident was transferred to hospital for an assessment.

A referral was made to the RD indicating that the resident was having frequent vomiting and staff were questioning whether or not an adjustment in food portion size and type and positioning after meals would be warranted.

A second referral was made to the RD indicating that the resident needed to be re-assessed for swallowing as they were showing signs of aspiration.

The RD assessed the resident on a day in May 2016, related to the frequent vomiting and difficulty swallowing. Documentation indicated, that at that time, the RD observed no concerns related to swallowing, however, indicated that if the resident displayed signs of not tolerating their diet texture, staff were to send another referral to the RD. The RD also indicated that the resident did not have any further incidents of vomiting, however, if it became problematic in the future, staff were to notify the RD.

A review of the progress notes, indicated that after the RD assessment dated in May, 2016, the resident experienced vomiting and difficulty swallowing on 12 separate occasions. No further referrals were made to the RD.

During an interview, the RD indicated to Inspector #575 that they reviewed the progress notes after their assessment in May 2016, there were further incidents of vomiting. The RD indicated that they were not aware, and the expectation was that staff would have reported that to the RD via a referral. The RD explained that once they received a referral and assessed the resident, they would indicate on the

referral to 'see the progress notes'. This note was also put in the shift report and 24 hour report for the staff to review. All registered staff review the shift reports and 24 hour reports and every morning there was a risk meeting. Any interventions that were implemented would be put on the 24 hour report.

During an interview, the Inspector asked the Acting ADOC #107 about the referral process and how staff follow up with the RD after the RD assessment. The Acting ADOC #107 stated that usually registered staff would send a referral and when the RD reviews it they would sign off on it with their assessment or say to look in the progress notes. The registered staff are to review the progress notes from the previous shifts at shift report. The Acting ADOC #107 explained that if there was something the RD wanted staff to monitor, it could have been entered into the resident's Electronic Medication Administration Record (eMAR) to track and monitor. The Inspector asked if the registered staff would have read the assessment note written by the RD in May 2016, indicating that the RD wanted to be made aware of further problems with vomiting and they stated that the staff might not have read back far enough.

The Inspector reviewed the physician's notes regarding this resident. The physician indicated that the resident was probably aspirating with a frequent congested cough and that they were on a certain textured diet.

During an interview with the resident's primary PSW during evening shift (#102), they stated to the Inspector that the resident had not had any difficulty swallowing and that they had always vomited after eating.

During an interview with day shift RN #112, they stated to the Inspector that the resident had not had any difficulty swallowing or with vomiting that they knew of. The RN also stated that once the RD completed their assessment/referral, they would usually verbally report their findings to the registered staff.

The Inspector determined that staff had not communicated and collaborated in the development and implementation of the resident's plan of care as the resident continued to have episodes of vomiting and difficulty swallowing and the RD was not made aware. [s. 6. (4) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in April 2016, regarding a controlled substance missing and or unaccounted for. The CI report indicated that in April 2016, while the pharmacist was in the process of drug destruction, they noticed that only nine vials of a controlled substance were in the drug destruction box, however, there should have been 10.

The Inspector reviewed the home's policy titled, "Drug Destruction and Disposal", dated January 2014. The policy indicated that the nurse who processes an order

to discontinue a monitored medication, was responsible for removing the medications from the medication cart double locked area during the shift count. The 'Shift Change Monitored Count' form was to be used at shift change and signed by both registered staff and the quantity of medication was to be verified with the 'Individual Monitored Medication Record'. The same two registered staff were responsible to complete and double sign the medication onto the "Drug Destruction and Disposal" form and place the medication into a locked monitored drug storage until destruction takes place.

During an interview with ADOC #106, they explained to the Inspector that there were three staff involved and they had not followed the home's policies and procedures related to shift change count and drug destruction. A resident was prescribed a controlled substance in April 2016, however they passed away, and had not required the use of the medication. The RPN who was working during the night shift pre-filled the 'Drug Destruction and Disposal Monitored Substances' record, however, this should have been done during the shift change count with two registered staff. The night RPN (#108) and the day RPN (#109) both signed the 'Drug Destruction and Disposal Monitored Substances' record, however, they had not counted the medication together and it was actually RPN #109 and RPN #110 who physically placed the medication in the destruction box. All RPNs signed that there were 10 vials, however, they did not recall counting them. When the pharmacist came in to destroy the medications in April 2016, there were only nine vials in the destruction box. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Inspector #575 reviewed a report submitted to the Director's After Hour Pager from June 2016, regarding the unexpected death of resident #001. The report indicated that resident #001 was being assisted with their meal when they choked. When the Registered Nurse (RN) attended, the resident was blue.

A Critical Incident (CI) report was submitted to the Director in June 2016, regarding the unexpected death of resident #001. The CI report indicated that during a meal service resident #001 was observed choking and vomiting. Despite interventions implemented by staff, the resident passed away.

During an interview with Inspector #575 on June 22, 2016, PSW #102 stated that while they were clearing the tables after the meal service, they noticed that resident

#001 had vomited. The PSW stated that the resident was awake, sweating, and they were turning purple. The PSW notified RPN #119 immediately, and attempted to clean up the resident. The PSW stated that the RPN then notified RN #103, who arrived one or two minutes later. The PSW stated that the resident stopped breathing when they were in their chair. The PSW stated that they received training on what to do when someone was choking; they are to do the Heimlich Manoeuvre. The PSW indicated that they had not performed the Heimlich Manoeuvre because they were nervous, therefore, they called the RPN to assist immediately.

During an interview with the Inspector on June 22, 2016, RN #103 stated that they were on another floor when they received a page to attend to the resident on another floor in the dining room. When RN #103 arrived, staff were attempting to remove discharge from the resident's mouth. The RN stated that they asked RPN #119 to confirm the resident's advanced directives and then attempted the Heimlich Manoeuvre. The RN then moved the resident to the floor, rolled them into recovery position, attempted a back blow, rolled the resident onto their back and attempted a jaw thrust, however, there was no air movement. The RN was then informed the resident had a DNR order, therefore, CPR was not performed. The RN stated that the resident's pulse and breath sounds were absent and they already had signs of lack of blood flow. The resident was then brought to their room, the physician was called and arrangements were made to pronounce the death of the resident. The RN stated that the suctioning machine was not used because it was not available in the dining room.

During an interview, the DOC stated to Inspector #575, that when a resident was choking or in distress, staff were expected to react immediately and they all had annual education regarding assisting a choking victim. The DOC explained that they are to stand back if the resident was able to cough and if not, they were to perform the Heimlich Manoeuvre, perform suctioning if required and call 911.

On June 22, 2016, Inspector #575, interviewed PSW #101 who assisted the resident with their meal. The PSW stated that the resident had not had any difficulty swallowing during the meal service. The Inspector asked the PSW if they received training on what to do if a resident was choking. The PSW stated call for help, and that usually the nurses would deal with it. Upon review of the home's investigation notes, PSW #101 did not have 'Aid to Choking' education as far as they could remember.

The home's policy titled 'Emergency Procedures: Aid to Choking', #CLIN-04-01-03,

indicated that all caregiving staff would be competent in providing aid to a choking victim. Registered staff are required to demonstrate competency in airway obstruction, including complete airway obstruction from conscious to unconscious victims; care aides, recreational and rehabilitation aides, are required to demonstrate complete airway obstruction for the conscious victim.

The home's policy titled 'Emergency Procedures: Aid to Choking, Methods', #CLIN-04-01-02, indicated steps in clearing an airway obstruction. For a complete airway obstruction, if the resident is conscious, staff are to perform the Heimlich Manoeuvre and repeat until the obstruction is cleared or the resident becomes unconscious. If the resident becomes unconscious, staff are to call the EMS system, perform a tongue-jaw lift and a finger sweep, open the airway, perform rescue breathing, and if that is not effective, deliver abdominal thrusts.

The home's policy titled 'Emergency Procedures: Suctioning of the Airway', #CLIN-04-03-03, indicated that emergency suctioning must be based on demonstrated need and the suction machine must be easily accessible and in optimum working condition and available at all times for emergency use. The policy further stated that all nursing staff shall demonstrate competency or review the emergency suctioning procedure at orientation and annually thereafter.

On June 29, 2016, Inspector #575 observed the suction machine in the medication room with RPN #109. The Inspector asked the RPN to set up the suction machine. The RPN began to set up the machine and stated that the power cord was missing. During an interview with the Inspector, RPN #109 stated that they received training on using the suction machine at some point, but not annually. The RPN stated that they thought there was a checklist for night shift staff to ensure the suction machine was working and ready.

On June 30, 2016, the Inspector and ADOC #106 observed the suction machine in the medication room. The ADOC confirmed that the power cord was missing and that it had not been reported to management. ADOC #106 stated that night shift staff were to check the suction machines every Saturday and make sure they are charged and stocked. The Inspector and ADOC reviewed the checklist for night shift for the month of June and noted that the check was not completed on June 18, 2016. [s. 8. (1) (b)]

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 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 :

1. The licensee has failed to ensure that the nutrition care and hydration programs

included the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration.

A Critical Incident (CI) report was submitted to the Director in June 2016, regarding the unexpected death of resident #001 due to choking. The CI report indicated that during meal service it was noted that the resident was vomiting and they were purple blue in color. Attempts were unsuccessful in achieving air exchange. The resident passed away.

A review of the resident's health care record was conducted by Inspector #575. The resident was admitted in March 2016. A 'Nutrition - Registered Dietitian Assessment' was completed in April 2016, that indicated the resident was ordered a certain textured diet. It was documented that the resident had swallowing difficulty. The 'Nutrition- Priority Screen' completed in April 2016, indicated that the resident was at nutritional risk.

A referral was made to the RD indicating that the resident was having frequent vomiting and staff were questioning whether or not an adjustment in food portion size and type would be warranted and positioning after meals.

A second referral was made to the RD indicating that the resident needed to be re-assessed for swallowing as they were showing signs of aspiration.

The RD assessed the resident on a day in May 2016, related to the frequent vomiting and difficulty swallowing. Documentation indicated, that at that time, the RD observed no concerns related to swallowing, however, indicated that if the resident displayed signs of not tolerating their diet texture, staff were to send another referral to the RD. The RD also indicated that the resident did not have any further incidents of vomiting, however, if it became problematic in the future, staff were to notify the RD.

A review of the progress notes, indicated that after the RD assessment dated in May, 2016, the resident experienced vomiting and difficulty swallowing on 12 separate occasions. No further referrals were made to the RD. No further referrals were made to the RD.

During an interview, the RD indicated to the Inspector that they reviewed the progress notes after their assessment in May 2016, and there were further incidents of vomiting. The RD indicated that they were not aware, and the

expectation was that staff would have reported that to the RD via a referral.

The resident's plan of care was reviewed by the Inspector and did not include interventions to mitigate the risks associated with swallowing or vomiting. [s. 68. (2) (c)]

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 nutrition care and hydration programs included the implementation of interventions to mitigate and manage the identified risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

Issued on this 13 day of October 2016 (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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : TIFFANY BOUCHER (543) - (A1)

Inspection No. / No de l'inspection : 2016_282543_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 000304-16, 012332-16, 014523-16, 017112-16, 018644-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 13, 2016;(A1)

Licensee / Titulaire de permis : EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700,
MARKHAM, ON, L3R-9W2

LTC Home / Foyer de SLD : EXTENDICARE FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON,
P3A-5K4

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Laura Halloran

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

Ministère 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

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) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, 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
(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).

Order / Ordre :

The licensee shall ensure 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 different aspects of care are integrated and are consistent with and complement each other.

Grounds / Motifs :

1. 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 different aspects of care were integrated and were consistent with and complemented each other.

Inspector #575 reviewed a report submitted to the Director's After Hour Pager in June, 2016, regarding the sudden death of resident #001. The report indicated that resident #001 was being assisted with their meal when they choked. When the Registered Nurse (RN) attended, the resident was blue.

The Critical Incident submitted to the Director in June, 2016, indicated that during the meal service on a day in June, 2016, resident #001 was observed choking and vomiting. Despite interventions implemented by staff, the resident passed away.

A review of the resident's health care record was conducted by the Inspector. The resident was admitted in March, 2016. A 'Nutrition - Registered Dietitian Assessment' was completed in April, 2016, that indicated the type of diet the resident was ordered. It was documented that the resident had difficulty swallowing. The 'Nutrition- Priority Screen' completed in April, 2016, indicated that the resident was at moderate nutritional risk.

A progress note from April, 2016, indicated that the RPN had requested the RN to assess the resident because it appeared that the resident aspirated on their own vomit.

On a day in April, 2016, a referral was made to the Registered Dietitian (RD) indicating that the resident often coughed. The referral indicated that the resident was trialled on a specific type of diet.

Another progress note from April 2016, written by the RD indicated that the texture of diet previously trialled was successful and that there had been no documentation of swallowing or coughing problems.

A progress note from May 2016, indicated that the resident had a large bout of emesis and staff were unsure if the resident had aspirated. The resident was transferred to hospital for an assessment.

A referral was made to the RD indicating that the resident was having frequent vomiting and staff were questioning whether or not an adjustment in food portion size and type would be warranted and positioning after meals.

A second referral was made to the RD indicating that the resident needed to be re-assessed for swallowing as they were showing signs of aspiration.

The RD assessed the resident on a day in May, 2016, related to the frequent vomiting and difficulty swallowing. Documentation indicated, that at that time, the RD observed no concerns related to swallowing, however, indicated that if the resident displayed signs of not tolerating their diet texture, staff were to send another referral

to the RD. The RD also indicated that the resident had not had any further incidents of vomiting, however, if it became problematic in the future, staff were to notify the RD.

A review of the progress notes which indicated that after the RD assessment, the resident experienced vomiting and difficulty swallowing on 12 separate occasions. No further referrals were made to the RD.

During an interview, the RD indicated to Inspector #575, that they reviewed the progress notes of their assessment in May, 2016, and there were further incidents of vomiting. The RD indicated that they were not aware, and the expectation was that staff would have reported that to the RD via a referral. The RD explained that once they received a referral and assessed the resident, they would indicate on the referral to 'see the progress notes'. This note was also put in the shift report and 24 hour report for the staff to review. All registered staff review the shift reports and 24 hour reports and every morning there is a risk meeting. Any interventions that are implemented would be put in the 24 hour report.

During an interview, the Inspector asked the Acting ADOC #107 about the referral process and how staff follow up with the RD after the RD assessment. The Acting ADOC #107 stated that usually registered staff would send a referral and when the RD reviews it they would sign off on it with their assessment or say to look in the progress notes. The registered staff are to review the progress notes from the previous shifts at shift report. The Acting ADOC #107 explained that if there was something the RD wanted staff to monitor, it could have been entered into the resident's Electronic Medication Administration Record (eMAR) to track and monitor. The Inspector asked if the registered staff would have read the assessment note written by the RD, indicating that the RD wanted to be made aware of further problems with vomiting and they stated that the staff might not have read back far enough.

The Inspector reviewed the physician's notes regarding this resident. The physician indicated that the resident was probably aspirating with a frequent congested cough and they were on a certain textured diet.

During an interview with the resident's primary PSW during evening shift (#102), they stated to the Inspector that the resident had not had any difficulty swallowing and that they had always vomited, after eating.

During an interview with day shift RN #112, they stated to the Inspector that the resident had not had any difficulty swallowing or with vomiting that they knew of. The RN also stated that once the RD completed their assessment/referral, they would usually verbally report their findings to the registered staff.

The Inspector determined that staff had not communicated and collaborated in the development and implementation of the resident's plan of care as the resident continued to have episodes of vomiting and difficulty swallowing and the RD was not made aware.

The decision to issue this compliance order was based on the previous history of written notifications and voluntary plan of corrections related to residents' plan of care, from inspections #2015_320612_0025, #2015_282543_0014, #2015_380593_0009, #2014_283544_0031, #2014_283544_0017 and #2014_336580_0008, the severity identified a potential for actual harm and although the scope was isolated to one resident.

(575)

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

Nov 30, 2016(A1)

Order # /
Ordre no : 002

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

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

1) The licensee shall ensure the following:

a) that their "Emergency Procedures: Aid to Choking", #CLIN-04-01-03, "Emergency Procedures: Aid to Choking, Methods", #CLIN-04-01-02 and their "Emergency Procedures: Suctioning of the Airway", #CLIN-04-03-03, policies are complied with,

b) provide training or retraining to all caregiving staff for the above mentioned policies, and

c) maintain a record of the required training or retraining, who completed the training or retraining, and dates the training occurred.

2) The licensee shall ensure the following:

a) that their 'Drug Destruction and Disposal' Policy is complied with,

b) that the home's staff who are involved in the administration or destruction of
medications review the above mentioned policy, and

c) that they maintain a record of all staff who were required to review the policy.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #575 reviewed a report submitted to the Director's After Hour Pager, regarding the unexpected death of resident #001. The report indicated that, resident #001 was being assisted with their meal when they choked. When the Registered Nurse (RN) attended, the resident was blue.

A Critical Incident (CI) report was submitted to the Director in June, 2016, regarding the unexpected death of resident #001. The CI report indicated that during a meal service, resident #001 was observed choking and vomiting. Despite interventions implemented by staff, the resident passed away.

During an interview with Inspector #575 on June 22, 2016, PSW #102 stated that while they were clearing the tables after the meal service, they noticed that resident #001 had vomited. The PSW stated that the resident was awake, sweating, and they were turning purple. The PSW notified RPN #119 immediately, and attempted to clean up the resident. The PSW stated that the RPN then notified RN #103, who arrived one or two minutes later. The PSW stated that the resident stopped breathing when they were in their wheelchair. The PSW stated that they received training on what to do when someone was choking; they are to do the Heimlich Manoeuvre. The PSW indicated that they had not performed the Heimlich Manoeuvre because they were nervous, therefore, they called the RPN to assist immediately.

During an interview with the Inspector on June 22, 2016, RN #103 stated that they were on another floor when they received a page to attend to the resident on another floor in the dining room. When RN #103 arrived, staff were attempting to remove discharge from the resident's mouth. The RN stated that they asked RPN #119 to confirm the resident's advanced directives and then attempted the Heimlich Manoeuvre. The RN then moved the resident to the floor, rolled them into recovery position, attempted a back blow, rolled the resident onto their back and attempted a jaw thrust, however, there was no air movement. The RN was then informed the resident had a DNR order, therefore, CPR was not performed. The RN stated that the resident's pulse and breath sounds were absent and they already had signs of lack of blood flow. The resident was then brought to their room, the physician was called and arrangements were made to pronounce the death of the resident. The RN stated that the suctioning machine was not used because it was not available in the dining room.

During an interview, the DOC stated to Inspector #575, that when a resident was choking or in distress, staff were expected to react immediately and they all had annual education regarding assisting a choking victim. The DOC explained that they are to stand back if the resident was able to cough and if not, they were to perform the Heimlich Manoeuvre, perform suctioning if required and call 911.

On June 22, 2016, Inspector #575, interviewed PSW #101 who assisted the resident with their meal. The PSW stated that the resident did not have any difficulty swallowing during the meal service. The Inspector asked the PSW if they received training on what to do if a resident was choking. The PSW stated call for help, and that usually the nurses would deal with it. Upon review of the home's investigation notes, PSW #101 did not have 'Aid to Choking' education as far as they could remember.

The home's policy titled 'Emergency Procedures: Aid to Choking', #CLIN-04-01-03, indicated that all caregiving staff would be competent in providing aid to a choking victim. Registered staff are required to demonstrate competency in airway obstruction, including complete airway obstruction from conscious to unconscious victims; care aides, recreational and rehabilitation aides, are required to demonstrate complete airway obstruction for the conscious victim.

The home's policy titled 'Emergency Procedures: Aid to Choking, Methods', #CLIN-04-01-02, indicated steps in clearing an airway obstruction. For a complete airway obstruction, if the resident is conscious, staff are to perform the Heimlich Manoeuvre and repeat until the obstruction is cleared or the resident becomes unconscious. If the resident becomes unconscious, staff are to call the EMS system, perform a tongue-jaw lift and a finger sweep, open the airway, perform rescue breathing, and if that is not effective, deliver abdominal thrusts.

The home's policy titled 'Emergency Procedures: Suctioning of the Airway', #CLIN-04-03-03, indicated that emergency suctioning must be based on demonstrated need and the suction machine must be easily accessible and in optimum working condition and available at all times for emergency use. The policy further stated that all nursing staff shall demonstrate competency or review the emergency suctioning procedure at orientation and annually thereafter.

On June 29, 2016, Inspector #575 observed the suction machine in medication room

with RPN #109. The Inspector asked the RPN to set up the suction machine. The RPN began to set up the machine and stated that the power cord was missing. During an interview with the Inspector, RPN #109 stated that they received training on using the suction machine at some point, but not annually. The RPN stated that they thought there was a checklist for night shift staff to ensure the suction machine was working and ready.

On June 30, 2016, the Inspector and ADOC #106 observed the suction machine in the medication room. The ADOC confirmed that the power cord was missing and that it had not been reported to management. ADOC #106 stated that night shift staff were to check the suction machines every Saturday and make sure they are charged and stocked. The Inspector and ADOC reviewed the checklist for night shift for the month of June and noted that the check was not completed on June 18, 2016.

The decision to issue this compliance order was based on the previous history of a written notification and a voluntary plan of correction from inspections #2015_332575_0002 and #2015_282543_0014, the severity identified a potential for actual harm and the scope in this case, is widespread as the home's policies affect the safety, well-being, and quality of life of all residents. (543)

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Inspector #575 reviewed a Critical Incident (CI) report submitted to the Director in April, 2016, regarding a controlled substance missing/unaccounted for. The CI report indicated that in April, 2016, while the pharmacist was in the process of drug destruction, they noticed that only nine vials of a controlled substance were in the drug destruction box, however, there should have been 10.

The Inspector reviewed the home's policy titled, 'Drug Destruction and Disposal', dated January 2014. The policy indicated that the nurse who processes an order to discontinue a monitored medication, was responsible for removing the medications from the medication cart double locked area during the shift count. The 'Shift Change Monitored Count' form was to be used at shift change and signed by both registered staff and the quantity of medication was to be verified with the 'Individual Monitored Medication Record'. The same two registered staff were responsible to

complete and double sign the medication onto the 'Drug Destruction and Disposal' form and place the medication into a locked monitored drug storage until destruction takes place.

During an interview with ADOC #106, they explained to the Inspector that there were three staff involved and they had not followed the home's policies and procedures related to shift change count and drug destruction. A resident was prescribed a controlled substance, however they passed away and had not required the use of the medication. The RPN who was working during the night shift pre-filled the 'Drug Destruction and Disposal Monitored Substances' record, however, this should have been done during the shift change count with two registered staff. The night RPN (#108) and the day RPN (#109) both signed the 'Drug Destruction and Disposal Monitored Substances' record, however, they had not counted the medication together and it was actually RPN #109 and RPN #110 who physically placed the medication in the destruction box. All RPNs signed that there were 10 vials, however, they did not recall counting them. When the pharmacist came in to destroy the medications in April, 2016, there were only 9 vials in the destruction box.

The decision to issue this compliance order was based on the previous history of a written notification and a voluntary plan of correction from inspections #2015_332575_0002 and #2015_282543_0014, the severity identified a potential for actual harm and the scope in this case, is widespread as the home's policies affect the safety, well-being, and quality of life of all residents.
(575)

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

Nov 30, 2016(A1)

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

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 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
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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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
Toronto ON M5S 2B1
Télécopieur : 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 13 day of October 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : TIFFANY BOUCHER - (A1)

Service Area Office /
Bureau régional de services : Sudbury