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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 7, 2017	2017_633577_0018	017003-17	Resident Quality Inspection

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

DEBBIE WARPULA (577), ALAIN PLANTE (620), MICHELLE BERARDI (679), SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): August 28-31 and September 1, 5, 6-8, 2017

The following intakes were inspected:
Three Critical Incident System (CIS) reports submitted by the home related to resident to resident abuse;

One Complaint submitted to the Director related to resident to resident abuse;

One Critical Incident System (CIS) report submitted by the home related to medication administration;

Two Complaints submitted to the Director related to care concerns; and

One Complaint submitted to the Director related to pain management and multiple care concerns.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOCs), Support Services Manager (SSM), Maintenance, Resident Assessment Instrument (RAI) Coordinator, Registered Practical Nurse Coding Lead, Program Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and families.

The inspector(s) also conducted daily tours of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed health care records, internal investigations and policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **7 WN(s)**
- **4 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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a particular day in September 2017, Inspector #620 observed RPN #105 administer medication to resident #019.

A record review of resident #019's medication administration record (MAR) indicated that the resident was to receive a specific medication with their meals three times daily, with particular guidelines.

On the same day in September 2017, Inspector #620 observed RPN #105 administer the prescribed medication without conducting a particular assessment prior to the administration of the prescribed medication. RPN #105 told the Inspector that they should have conducted a particular assessment before providing the medication. They indicated that they could not be sure the correct dose had been administered because the resident's particular assessment had not been completed at the time of administration.

Inspector #620 reviewed a document titled, "Medication Pass-3-6" with a revision date of February 2017. The document advised staff that each resident was to receive the correct medication, at the prescribed dosage, and at the correct time.

Inspector #620 interviewed the DOC who indicated that RPN #105 should have conducted a current assessment as indicated by the resident's particular guideline before administering the prescribed medication to the resident. They confirmed that the medication was not administered to the resident as prescribed. [s. 131. (2)]

2. Inspector #620 reviewed a Critical Incident System report that was submitted by the home to the Director on a day in 2016. The report described a medication incident where resident #009 had not received a medication as prescribed for 23 of 45 days.

A review of resident #009's clinical record indicated that the resident was admitted to the home during a specific month in 2016. A document signed by the Physician and titled, "Admission Orders" dated during the month of their admission in 2016, had an entry which indicated that resident #009 was to receive a specific medication daily. A review of the resident's MAR indicated that resident #009 was to receive their medication at a specific time and that the medication was stored in a separate card.

A review of the home's investigation documents revealed that on a day one month after the residents admission in 2016, the home's Pharmacy Consultant was on site in the

home conducting audits and discovered the medication error involving resident #009. The home had determined that for a 45 day duration the resident had not been administered their medication on 23 occasions. Interviews within the investigation documents with 13 registered staff members revealed that many of the 13 registered staff had documented the administration of resident #009's medication despite the administration not having occurred. All 13 registered staff members observed that there were multiple doses of the resident's medication not administered; however, no medication incidents were submitted as required by the homes medication error policy.

Inspector #620 reviewed a document titled, "Medication Pass-3-6" last revised February 2017. The document advised staff that each resident was to receive the correct medication, at the prescribed dosage, and at the correct time.

Inspector #620 interviewed home's Medication Management Lead (ADOC #107) who indicated that the incident involving resident #009 was a systemic failure of the home's medication administration process. They indicated that many of the registered staff involved had documented administration of the medication when it had not occurred, and many were aware, and had not reported, numerous observations of errors of omission.

Inspector #620 interviewed the home's DOC who indicated that in the medication incident involving resident #009, many staff had failed to ensure that the resident's medication was provided as prescribed. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in December 2016, which identified abuse between resident #014 and resident #015. As per the report, resident #015 sustained an injury.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in January 2017, which identified abuse between resident #014, resident #017 and resident #018. The report indicated that resident #014 caused injury to resident #018.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in January 2017, which identified abuse between resident #014 and resident #016. The CI report revealed that in January 2017, resident #014 wandered into resident #016's room and caused injury to resident #016.

Inspector #577 reviewed the home's policy titled "Responsive Behaviours - RC-17-01-04" last revised February 2017, which indicated that the care plan should include the following:
-a description of the behaviour;
-triggers to the behaviour;
-preventative measures to minimize the risk of the behaviour developing or escalating;
-resident specific interventions to address behaviours; and
-strategies staff were to follow if the interventions were not effective.

A review of resident #014's health care record revealed that resident #014 had nine incidents of physical aggression towards other residents that were documented in the electronic progress notes over a six month period.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), dated February 2017, identified resident #014's Cognitive Performance Scale (CPS) was categorized as moderate cognitive impairment.

A review of resident #014's care plan effective at the time of the physically responsive behaviours, over a two month period indicated specific interventions related to their responsive behaviours.

A review of resident #014's progress notes indicated that resident #014 had a responsive behaviour intervention over a four day period in 2016, and nineteen consecutive days in 2017. The intervention was discontinued on a specific day. Then on a particular day (20 days later) resident #014 had an altercation with resident #019. Subsequently four days after the altercation, the resident was transferred from the home to an acute care facility.

The Inspector spoke with PSW #117 who reported that resident #014 had responsive behaviours towards other residents and staff would implement one of the responsive interventions as identified in the care plan.

The Inspector spoke with RPN #118 who reported that resident #014 had responsive behaviours towards staff and residents.

The Inspector spoke with RPN #119 who reported that resident #014 had responsive behaviours towards residents and staff would implement the same intervention as described by PSW #117. PSW #120 reported that the resident #014 had responsive behaviours towards staff and residents. They further reported that staff would provide specific interventions to mitigate their behaviours.

The Inspector conducted an interview with the ADOC #115 who reported that the resident was provided a specific responsive behaviour intervention for three consecutive weeks in 2017. They further confirmed that the home failed to protect the residents from resident #014's responsive behaviours and the care plan interventions, which included triggers and interventions, were not updated until eight incidents of responsive behaviours to other co-residents had occurred. [s. 54. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Resident #002 was identified as having a prevalence of lack of corrective action for communication problems through a Minimum Data Set (MDS) assessment of previous to most recent.

A review of the current MDS/RAPS assessment identified that resident #002 had specific communication problems. Resident #002's COMM score indicated mild communication impairment and would be addressed in the care plan.

A review of the current care plan, revealed no focus or interventions related to communication for resident #002. In an interview with Inspector #679, RPN Coding Lead #104 identified that resident #002 had difficulty with communicating. RPN Coding Lead #104 identified that resident #002's communication issues were not addressed in their care plan.

A review of the policy entitled "Care Planning" dated September, 2010, outlined that "registered staff and other members of the interdisciplinary care team are responsible for updating the resident's plan of care to ensure it remains current and reflective of the care needs of the resident at any given point in time".

In an interview with the DOC they identified that if a resident was exhibiting a communication barrier this would typically be reflected in the care plan. [s. 6. (1)]

2. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to the resident.

A complaint was received by the Director in July 2017, concerning resident to resident abuse. Inspector #577 conducted a record review of resident #013's electronic care plan specific to behaviours, with an updated intervention on a particular day in August 2017.

The Inspector reviewed the paper care plan found in a care plan binder on the unit for resident #013, with a print date for a day in May 2017. The care plan did not include the updated intervention dated August 2017. A review of the electronic kardex did not contain the updated intervention.

Inspector #577 reviewed the home's policy titled "Care Planning - #03-01-02", last updated September 2010, which indicated the following:
-registered staff and other members of the interdisciplinary care team were responsible for updating the resident's plan of care to ensure it remained current and reflective of the care needs of the resident at any given point in time;
-a paper copy of the completed care plan was to be printed and retained at the nurse's station or in the location designated by the home for reference and emergency planning purposes;
-the paper care plan was to be kept current to the care needs of the residents; and
-as the resident's status changed, members of the interdisciplinary team were to update the resident's care plan so that at any given point in time the care plan was reflective of the current needs of the resident.

During an interview with PSW #121 they reported that they reviewed the electronic kardex and paper care plan for resident information.

During an interview with RPN #122 they reported to the Inspector that the paper care plans in the care plan binder were updated and staff referred to them for information. Together, RPN #122 and the Inspector reviewed both the paper, electronic care plan and kardex. RPN #122 confirmed that the updated intervention dated August 2017, was not documented on the paper care plan or kardex. They further confirmed that the care plan was not re-printed after the update and the kardex was not updated.

During an interview with the DOC, they confirmed that registered staff were responsible for updating and re-printing the care plans and placing them in the care plan binders. They further confirmed that staff were responsible for reviewing the paper and electronic care plans and the kardex. [s. 6. (1) (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 written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #620 conducted an observation of the home's medication storage area on a particular home area. RPN #111 demonstrated to the Inspector the areas for medication storage. During the observation RPN #111 described that the narcotic storage cabinet had two doors, with individual locks. The Inspector asked if RPN #111 if they could open the cabinet. When RPN #111 was observed accessing the cabinet, they did so by unlocking one of the locks on one of the doors; the other door was observed by the Inspector to be unlocked. RPN #111 indicated that the medications stored within, were PRN (as needed) narcotics. Inspector #620 asked RPN #111 if it was the home's policy that the narcotic storage doors would only be secured with one of the locks, on one of the doors; they stated that they had not locked both doors as they were required to do, when they last accessed the cabinet.

Inspector #620 reviewed a documents titled, "Management of Narcotics and Controlled Drugs-RC-16-01-13" last revised February 2017. The document directed staff to "Store all narcotics and controlled drug(s) in a separate, double-locked stationary cupboard in a locked area..."

Inspector #620 interviewed the home's DOC who stated that the narcotics were to be stored in a locked medication room, and that the cabinet was to be double locked. They indicated that RPN #111 should have secured both locks after retrieving medication. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

The Long-Term Care Homes Act, 2007, C.8 describes a medication incident as "…a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes,
(a) an act of omission or commission, whether or not it results in harm, injury or death to a resident, or
(b) a near miss event where an incident does not reach a resident but had it done so, harm, injury or death could have resulted"

Inspector #620 conducted a review of the medication incident reports documented in the home. A review of the entire month of August 2017, revealed a total of 14 medication incidents. Of the 14 documented medication incidents, only two were reported to the Substitute Decision Maker (SDM) and the physician. The 12 incidents of concern were as follows:
-an error of omission was documented involving resident #033; both the physician and

SDM were not notified;
-an error of omission was documented involving resident #023; both the physician and SDM were not notified; and
-an error of omission was documented involving residents #025, #026, #027, #028, #029, #030, #031, #032, and #034; both the physician and SDM were not notified.

Inspector #620 reviewed the home's policy titled, "Medication Incident Reporting-9-1" dated February 2017. The policy directed staff that, "Every medication incident and adverse drug reaction involving a resident (excluding near miss) was to be reported to the resident's substitute decision maker, the Director of Nursing and Personal Care, the resident's attending physician and the pharmacy/Clinical Pharmacy Consultant." The policy further emphasized that, "Every medication incident and adverse drug reaction involving a resident directly will require a designate from the home to notify the resident, resident's substitute decision maker that an incident has reached the resident."

Inspector #620 interviewed the ADOC who indicated that of the 14 documented medication incidents, the physician and resident's SDM were only contacted in two of the occurrences. They confirmed that it was the home's policy that in every medication incident, the SDM and physician were to be notified and that this had not occurred. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

On a day in September 2017, Inspector #620 observed PSW #113 enter the room of resident #022. The Inspector observed that there was a sign posted to the left of the room door which stated specific precautions to be followed. The Inspector observed that PSW #113 entered the room, provided care to the resident without the use of those specific precautions. PSW #113 was then observed to carry soiled linens out of the resident's room, down a hallway to a soiled linen receptacle. PSW #113 did not wash their hands before or after providing direct care to resident #022.

A review of resident #022's clinical record revealed that resident #022 was on specific precautions. A review of the resident's care plan included an intervention that advised staff to follow specific precautions.

Inspector #620 reviewed a specific policy which directed staff to wear the Personal Protective Equipment (PPE) designated as posted on the sign at the resident's room, and perform hand hygiene when entering and exiting the resident's room.

Inspector #620 interviewed PSW #113 about the resident's specific precautions and the home's expectation with regards to PPE and hand hygiene. PSW #113 indicated that PPE was not required.

Inspector #620 interviewed RPN #114 who stated that if a resident was on specific precautions, staff were expected to apply the specific PPE as described for that specific precaution before providing direct resident care. They indicated that all staff were trained annually on the home's infection prevention and control program.

Inspector #620 interviewed ADOC #107 who indicated that when a resident was on specific precautions, staff were expected to don PPE when providing direct care to the resident. [s. 229. (4)]

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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

During observations on two days in August 2017, by Inspectors #620 and #679, residents #001, #003, #006, and #008's call systems (bedside call bells) were observed as being improperly placed or out of reach of the residents. The following observations

occurred:
- resident #001's call bell was observed by Inspector #620 to be under the resident's bed while the resident was occupying the bed;
- resident #008's call bell was observed by Inspector #620 to be under the resident's bed while the resident was occupying the bed; a PSW was observed to be leaving the room immediately prior to the observation;
- resident #003's call bell was observed by Inspector #679 to be on the floor behind the head of the bed while the resident was occupying in the bed; and
- resident #006's call bell was observed by Inspector #620 to be under the resident's bed while the resident was occupying the bed.

On another day in August 2017, Inspector #620 further observed that resident #001 was in their bed. The call bell was seen to be tied to the resident bed rail with an approximate 5 centimeter length from the call bells activation button. The Inspector asked the resident if they could activate their call bell. The resident indicated that they were unable to reach it. The Inspector activated the call bell and noted that the button to activate the call bell was stiff and difficult to activate. The Inspector untied the call bell from the bed rail and asked the resident to show them how they would activate the call system. The resident, using both hands, was unable to depress the button to activate the call bell.

Inspector #620 reviewed a document titled, "Nurse Call System-RC-08-01-01" last revised April 2017. The document directed staff to "Monitor to ensure the call bell was always within reach of the resident while resident was in their room." The document also instructed staff to, "check the call bell system every shift to ensure system was functional".

Inspector #620 interviewed RPN #105 who indicated that bedside call bells were to be within reach of residents at all times when they were in bed. They indicated that all staff providing care were required to ensure that the call system was in reach. They indicated that PSW staff were required to check the call bell every shift for functionality.

Inspector #620 interviewed the Support Services Manager (SSM). The SSM activated resident #001's bedside call bell and noted that it was not working properly, indicating that the button was too difficult to depress. The SSM also noted that the call bell clip used to attach the call bell to linens was broken. They noted that the call bell and its clip required replacement and that at no time were call bells to be tied to bed rails. They stated that staff had been educated to affix bedside call bells to bed linens only. They indicated that staff were required to ensure that call bells were working as required

during every shift and at any other time that they suspected a call bell malfunction. [s. 17. (1) (a)]

Issued on this 24th day of November, 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) :	DEBBIE WARPULA (577), ALAIN PLANTE (620), MICHELLE BERARDI (679), SHELLEY MURPHY (684)
Inspection No. / No de l'inspection :	2017_633577_0018
Log No. / No de registre :	017003-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Nov 7, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, 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

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 :

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

Order / Ordre :

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

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

On a particular day in September 2017, Inspector #620 observed RPN #105 administer medication to resident #019.

A record review of resident #019's medication administration record (MAR) indicated that the resident was to receive a specific medication with their meals three times daily, with particular guidelines.

On the same day in September 2017, Inspector #620 observed RPN #105 administer the prescribed medication without conducting a particular assessment prior to the administration of the prescribed medication. RPN #105 told the Inspector that they should have conducted a particular assessment before providing the medication. They indicated that they could not be sure the correct dose had been administered because the resident's particular assessment had not been completed at the time of administration.

Inspector #620 reviewed a document titled, "Medication Pass-3-6" with a revision date of February 2017. The document advised staff that each resident was to receive the correct medication, at the prescribed dosage, and at the correct time.

Inspector #620 interviewed the DOC who indicated that RPN #105 should have conducted a current assessment as indicated by the resident's particular guideline before administering the prescribed medication to the resident. They confirmed that the medication was not administered to the resident as prescribed. [s. 131. (2)]

2. Inspector #620 reviewed a Critical Incident System report that was submitted by the home to the Director on a day in 2016. The report described a medication incident where resident #009 had not received a medication as prescribed for 23 of 45 days.

A review of resident #009's clinical record indicated that the resident was admitted to the home during a specific month in 2016. A document signed by the Physician and titled, "Admission Orders" dated during the month of their admission in 2016, had an entry which indicated that resident #009 was to receive a specific medication daily. A review of the residents MAR indicated that resident #009 was to receive their medication at a specific time and that the medication was stored in a separate card.

A review of the home's investigation documents revealed that on a day one month after the residents admission in 2016, the home's Pharmacy Consultant was on site in the home conducting audits and discovered the medication error involving resident #009. The home had determined that for a 45 day duration the resident had not been administered their medication on 23 occasions. Interviews within the investigation documents with 13 registered staff members revealed that many of the 13 registered staff had documented the administration of resident #009's medication despite the administration not having occurred. All 13 registered staff members observed that there were multiple doses of the resident's medication not administered; however, no medication incidents were submitted as required by the homes medication error policy.

Inspector #620 reviewed a document titled, "Medication Pass-3-6" last revised February 2017. The document advised staff that each resident was to receive the correct medication, at the prescribed dosage, and at the correct time.

Inspector #620 interviewed home's Medication Management Lead (ADOC #107) who indicated that the incident involving resident #009 was a systemic failure of the home's medication administration process. They indicated that many of the registered staff involved had documented administration of the medication when

it had not occurred, and many were aware, and had not reported, numerous observations of errors of omission.

Inspector #620 interviewed the home's DOC who indicated that in the medication incident involving resident #009, many staff had failed to ensure that the resident's medication was provided as prescribed. [s. 131. (2)] (620)

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the home's medication administration process. They indicated that many of the registered staff involved had documented administration of the medication when it had not occurred, and many were aware, and had not reported, numerous observations of errors of omission.

Inspector #620 interviewed the home's DOC who indicated that in the medication incident involving resident #009, many staff had failed to ensure that the resident's medication was provided as prescribed. [s. 131. (2)]

The decision to issue a compliance order was based on the severity which was determined to be actual harm/risk and the scope which was determined to be a pattern.
(620)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 21, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee shall:

Ensure that for all residents demonstrating responsive behaviours, steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identifying and implementing interventions.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in December 2016, which identified abuse between resident #014 and resident #015. As per the report, resident #015 sustained an injury.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in January 2017, which identified abuse between resident #014, resident #017 and resident #018. The report indicated that resident #014 caused injury to resident #018.

Inspector #577 reviewed a Critical Incident System (CIS) report that was submitted to the Director in January 2017, which identified abuse between resident #014 and resident #016. The CI report revealed that in January 2017, resident #014 wandered into resident #016's room and caused injury to resident #016.

Inspector #577 reviewed the home's policy titled "Responsive Behaviours - RC-17-01-04" last revised February 2017, which indicated that the care plan should include the following:
-a description of the behaviour;
-triggers to the behaviour;
-preventative measures to minimize the risk of the behaviour developing or escalating;
-resident specific interventions to address behaviours; and
-strategies staff were to follow if the interventions were not effective.

A review of resident #014's health care record revealed that resident #014 had nine incidents of physical aggression towards other residents that were documented in the electronic progress notes over a six month period.

A review of the Resident Assessment Instrument-Minimum Data Set (RAI-MDS), dated February 2017, identified resident #014's Cognitive Performance Scale (CPS) was categorized as moderate cognitive impairment.

A review of resident #014's care plan effective at the time of the physically responsive behaviours, over a two month period indicated specific interventions related to their responsive behaviours.

A review of resident #014's progress notes indicated that resident #014 had a responsive behaviour intervention over a four day period in 2016, and nineteen consecutive days in 2017. The intervention was discontinued on a specific day. Then on a particular day (20 days later) resident #014 had an altercation with resident #019. Subsequently four days after the altercation, the resident was transferred from the home to an acute care facility.

The Inspector spoke with PSW #117 who reported that resident #014 had responsive behaviours towards other residents and staff would implement one of the responsive interventions as identified in the care plan.

The Inspector spoke with RPN #118 who reported that resident #014 had responsive behaviours towards staff and residents.

The Inspector spoke with RPN #119 who reported that resident #014 had responsive behaviours towards residents and staff would implement the same intervention as described by PSW #117. PSW #120 reported that the resident #014 had responsive behaviours towards staff and residents. They further reported that staff would provide specific interventions to mitigate their behaviours.

The Inspector conducted an interview with the ADOC #115 who reported that the resident was provided a specific responsive behaviour intervention for three consecutive weeks in 2017. They further confirmed that the home failed to protect the residents from resident #014's responsive behaviours and the care plan interventions, which included triggers and interventions, were not updated until eight incidents of responsive behaviours to other co-residents had occurred. [s. 54. (b)]

The decision to issue this compliance order was based on the severity which indicated actual harm/risk, the scope which was a pattern and the compliance history which indicated unrelated non compliance.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 21, 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, commercial courier 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Debbie Warpula

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