Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2019	2019_587129_0021	012356-19, 013434-19, 019762-19	Critical Incident System

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Hamilton
90 Chedmac Drive HAMILTON ON L9C 7S6

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

PHYLLIS HILTZ-BONTJE (129), DIANNE BARSEVICH (581)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 9, 10, 11, 12, 13, 16, 2019.

The following intakes were inspected:
CIS-012356-19 related to medication administration
CIS-019762-19 related to medication administration
CIS-013434-19 related to falls

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers, Registered Practical Nurses, Director of Care-Clerk, Clinical Practice Lead, Clinical Co-ordinator, Resident Assessment Instrument Co-ordinator, Pharmacist, Director of Care and the Administrator.

During the course of the inspection the Inspectors observed residents and care being provided, observed controlled drug destruction and storage of discontinued controlled drugs, reviewed clinical records, Medication Incident Reports, home's investigative notes related to medication incidents, licensee's policy's related to Medication Incident Reporting, Patch Disposal for Monitored Medication, Head Injury policy, Falls Policy, licensee's documents related to quarterly review of medication incidents and quarterly Professional Advisory Meetings.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

s. 6. (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).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out, clear direction to staff and others who provided direct care to the resident.

Resident #006's care plan was reviewed and it was identified that care directions related to transferring and the provision of specified personal care were not clear.

A review of the plan of care, specifically the Kardex, for resident #006 identified directions for assisting the resident during transfers and for providing specified personal care.

During an interview with Personal Support Worker (PSW) #106, they stated that they provide assistance for transfers and the specified personal care in a different manner than was identified in the Kardex noted above.

Following a review of the Kardex with PSW #106 and PSW #115, they both confirmed they provide assistance to the resident that was different than the directions that were identified in the Kardex and also confirmed that the Kardex did not provide clear direction

as to how and when the resident was to be transferred and how the specified personal care was to be provided.

Following a review of the written plan of care and Kardex with Registered Practical Nurse (RPN) #108, they confirmed that there was not clear direction to staff and others who provided direct care to resident #006 related to transfers and the provision specified personal care. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated and were consistent with each and complemented each other.

A review of the plan of care identified that resident #003 had a Safe Lift and Transfer Assessment completed by RPN #103 on and identified date, which directed the specific method for assisting the resident with transfers in order to provide specified personal care, as well as the amount of assistance the resident required.

A review of the Physiotherapist (PT) assessment completed two days prior to the Safe Lift and Transfer Assessment noted above, indicated the resident required an identified level of assistance for transfers, an assistive device was to be used and staff were to encourage the resident to participate in the transfer activity, which were different directions than the above noted assessment completed by RPN #103 provided.

Following a review of the plan of care with RPN #103, they stated when they completed the Safe Lift and Transfer Assessment, they observed two PSW staff transfer the resident and the PSWs told them that the resident would need less assistance in identified circumstance. RPN #103 acknowledged they usually collaborated with the PT in their transfer assessments; however, confirmed after they completed the Safe Lift and Transfer Assessment they did not speak with or review the PT assessment that was completed two days earlier.

RPN #103 confirmed that the Safe Lift and Transfer Assessment and the Physiotherapy Assessment for resident #003 were not integrated and consistent with each other and did not complement each other. [s. 6. (4) (a)]

3. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) During this inspection, resident #003 was observed to be transported by PSW #104 after breakfast to their room in order to provide personal care.

A review of the written plan of care for resident #003 identified they required a specific level of physical assistance related to the provision of the specified personal care .

During an interview with PSW #104, they stated the method and level of assistance they provided to resident #003 when they assisted the resident after breakfast.

Following a review of the Kardex with PSW #104, they confirmed they had not provided the level of assistance that was identified in the resident's plan of care during the above noted provision of care.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #003 as specified in the plan related to the specified personal care.

b) Registered staff did not provide resident #001, resident #004 and resident #005 with the care set out in the plan of care when they did not check and document a medication administered by a specific route, every shift.

The Medication Administration Record (MAR) for the three above noted residents specified that registered staff were to check and document the above noted medication every shift.

During a discussion with the Director of Care (DOC), they verified that it was the expectation that staff would make a note in the progress note section of the computerized clinical record to indicate they had checked two specific conditions related to the medication.

i) A review of resident #001's clinical notes for the first nine days of December 2019, confirmed that staff had not provided the care as specified on the resident's MAR and clarified by the DOC, when there was no indication in the progress notes that the resident had been checked for the two specific conditions related to the above noted medication on the following dates and shifts:
December 2, 2019 - night shift
December 3, 2019 - night shift
December 4, 2019 - day shift

December 5, 2019 - day and evening shifts
December 6, 2019 - day and evening shifts
December 7, 2019 - night shift
December 8, 2019 - evening and night shifts
December 9, 2019 - day shift

ii) A review of resident #004's clinical notes for the first nine days of December 2019, confirmed that staff had not provided the care as specified on the resident's MAR and clarified by the DOC, when there was no indication in the progress notes that the resident had been checked for the two specific conditions related to the above noted medication on the following dates and shifts:

December 2, 2019 - night shift
December 3, 2019 - evening and night shifts
December 4, 2019 - night shift
December 5, 2019 - evening and night shifts
December 6, 2019 - days, evening and night shifts
December 7, 2019 - evening shift
December 8, 2019 - evening and night shifts
December 9, 2019- night shift

iii) A review of resident #005's clinical notes for the first nine days of December 2019, confirmed that staff had not provided the care as specified on the resident's MAR and clarified by the DOC, when there was no indication in the progress notes that the resident had been checked for the two specific conditions related to the above noted medication on the following dates and shifts

December 2, 2019 - evening and night shifts
December 3, 2019 - evening and night shifts
December 4, 2019 - day, evening and night shifts
December 5, 2019 - evening and night shifts
December 6, 2019 - day and night shifts
December 7, 2019 - day shift
December 8, 2019 - day, evening and night shifts
December 9, 2019 - day , evening and night shifts

Registered staff did not provide care as specified in resident #001's, resident #004's and resident #005's plan of care when they failed to follow specific directions to check and document two conditions of the identified medication, ordered by the resident's physicians, as specified in the Medication Administration Record and clarified by the

DOC.(129) [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that the care set out in the plan of care is provided to the residents as specified in the plan, to be implemented voluntarily.

WN #2: 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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) Resident #002's physician ordered the resident to receive an identified medication administered by a specified route, in a specified dose, to be administered continuously and the clinical record confirmed that this was a current order during a specified month in 2019.

Clinical records, a Medication Incident Report (MIR) and a Critical Incident Report (CIR) submitted to the Director during the specified month, indicated that resident #002 had not received a continuous administration of the identified medication on an identified date in the specified month noted above.

A review of clinical notes indicated that on the identified date, staff noted that the resident had not been receiving the identified medication.

Based on information available at the time of this inspection, it was possible that resident

#002 could have been without the continuous administration of this medication for a five to six hour period of time. A review of the clinical record over this period of time indicated there was no documentation to indicate the resident experienced a negative effect as a result of not receiving this medication through the above noted period of time.

b) Resident #001's physician ordered the resident to receive an identified medication administered by a specified route, in a specified dose, to be administered continuously and the clinical record confirmed that this was a current order during a specified month in 2019.

A review of clinical records and a MIR indicated that resident #002 had not received a continuous administration of the identified medication on an identified date in the specified month noted above.

Based on the information available at the time of this inspection, it was possible that resident #001 could have been without the continuous administration of this medication a 12 to 13 hour period of time. A review of the clinical record over this period of time indicated there was no documentation to indicate the resident experienced a negative effect as a result of not receiving this medication through the above noted period of time.

Registered staff failed to ensure that resident #002 and resident #001 received a continuous application of an identified medication, as was specified by the resident's physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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 failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy, was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

At the time of this inspection the Director of Care provided an identified licensee policy that provided specific directions staff were to follow in related to the management of an identified medication that was to be administered by a specific route as well as a process for the disposal of this medication.

The licensee failed to ensure that the above noted directions contained in the above noted policy were complied with.

On two identified dates in 2019, the Pharmacist confirmed that registered staff had not complied with the licensee's policy noted above, in relation to the management and disposal of the above noted medication administered by a specified route.

During the process of the disposal of surplus medications on an identified date, the Pharmacist noted that registered staff had not complied with the specific directions for the disposal of two of the above noted medications and that these medications were unaccounted for.

During a second process of the disposal of surplus medications that occurred three months after the above note disposal of surplus medications, the Pharmacist noted that registered staff had not complied with the specific directions for the disposal of one of the above noted medications and this medication was unaccounted for.

Investigative notes provided by the DOC at the time of this inspection indicated the three unaccounted medications identified had not been located.

Registered staff failed to comply with the licensee's policy noted above when during the process of disposing of surplus medications, the Pharmacist noted that staff had not complied with the directions contained in the licensee's policy when three identified medications administered by a specific route were unaccounted for. [s. 8. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the results of the annual evaluation of the effeteness of the medication management system and of any changes that were implemented

On December 13, 2019, the Administrator confirmed they were unable to provide a written record of the evaluation of the effectiveness of the medication management system for the 2018 calendar year. [s. 116. (5)]

Issued on this 6th day of January, 2020

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

Original report signed by the inspector.