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
Feb 15, 2018	2018_717531_0004	001404-18	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 Kingston
309 Queen Mary Road KINGSTON ON K7M 6P4

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

SUSAN DONNAN (531), CATHI KERR (641)

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): February 5, 6, 7, 8 and 9, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Program Manager (PM), the Registered Dietitian (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), the RAI Coordinator, Housekeeping Aide (HSKP), the President of the Residents' Council, residents Substitute Decision Makers (SDM) and residents.
During the course of the inspection the inspectors conducted a tour of the home, reviewed resident health care records, observed resident care and services, observed medication administration and procedures, reviewed medication incident reports, reviewed the Resident Council meeting minutes, reviewed skin and wound policies and procedures and the fall prevention and management program.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
3 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	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.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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 the care set out in plan of care related to continence care was provided to resident #031 as specified in the resident’s written plan of care.

In reference to log # 027342-17

On a specified date, a Critical Incident System Report (CIS) was submitted to the Director which indicated that resident #031 had sustained a fall.

A review of the CIS indicated a PSW responded to a noise heard from resident #031’s room and found the resident on the floor.

During an interview with PSW #120 on February 9, 2018, with inspector #531 the PSW indicated that on a specified date RPN # 119 requested assistance to transfer resident #031 for continence care. PSW #120 indicated that resident #031 was provided with the call bell and instructed to ring when assistance was required. PSW #120 further indicated that resident #031's plan of care had not been reviewed and the PSW was not aware that resident #031 was not to be left unattended . PSW #120 indicated that resident #031 was found on the floor a short time later.

On the same day during an interview with RPN #119, the RPN indicated resident #031 had requested assistance to be transferred for continence care prior to attending an activity. The RPN indicated that resident #031 required two staff to transfer the resident therefore requested assistance from PSW #120 . RPN #119 indicated that the resident was provided with the call bell and instructed to ring for assistance. RPN #119 further indicated that they responded to the resident’s call bell after a short time and was informed by the resident that more time was required and would ring when finished. RPN #119 indicated that resident #031 was found on the floor a short time later. RPN #119 further indicated that resident #031 had not had a fall for several months and the RPN was not aware that the resident's plan of care indicated that the resident was not to be left unattended.

During an interview with the Director of Care (DOC), the DOC indicated that the expectation is for care to be provided to residents as specified in the plan of care and acknowledged that the care was not provided to resident #031 as specified in the plan.
[s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided as specified in the resident written plan of care, 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 resident #028, #029 and #030 in accordance with the directions for use specified by the prescriber.

Inspector #641 reviewed the licensee's medication incidents for a specified three month period.
Three medication incidents were reviewed.

Inspector #641 reviewed resident #028's physician orders which indicated that the resident had been prescribed a specific medication to be administered at 1700 hours and a different medication at 2000 hours.

During an interview with Inspector #641 on February 8, 2018, the DOC indicated that on a specified date, RPN #111 administered the medication that had been prescribed for resident #028 for 1700 hours, at 2000 hours and not the specified 2000 medication. The DOC indicated that the RPN recognized the error at the end of the shift completed an incident report at that time. The ADON indicated that there were no untoward effects to the resident. RPN #111 was unavailable for an interview.

Inspector #641 reviewed resident #029's physician orders which indicated that the resident had been prescribed a specified medication before meals: the dose was dependent on a specific protocol .

During an interview with Inspector #641 on February 9, 2018, RPN #116 indicated that on a specified date, the RPN had conducted the specified protocol on resident #029 before the meal and that they gave the resident the specified medication at the time and then recognized that the resident should not have received the medication as directed by the protocol. RPN #116 specified that they had initiated a medication incident report, an assessment of the resident, the resident had been monitored, notified the resident and the resident's physician.

Inspector #641 reviewed the resident's health care record which indicated that the resident had been monitored every shift as was the expectation of the licensee.

Inspector #641 reviewed resident #030's physician orders which indicated that the resident had been prescribed a specific medication to be administered as required and a different medication at an identified time regularly.

RPN #117 indicated to the Inspector during an interview on February 9, 2018, that on a specified date the RPN had administered the as required specific medication to resident #030 at the identified time regularly instead of the medication prescribed for the identified time. RPN #117 specified that they recognized the error at the end of the shift. At that time, RPN #117 specified that they had initiated a medication incident report, an assessment of the resident and notified the resident and the resident's physician. RPN #117 indicated that the staff have a 24 hour report sheet that they use to alert the other shifts as to what had occurred on their shift, so the RPN had documented the incident on this report sheet as well. This would ensure that the resident would be monitored after the incident.

Inspector #641 reviewed resident #030's health care record which indicated that the resident had been assessed every shift as was the expectation of the licensee.

The licensee failed to ensure that drugs were administered to residents #028, #029 and #030 in accordance with the directions for use specified by the prescriber. [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 to ensure 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. 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 failed to ensure that every medication incident involving a resident is documented, together with a record of the immediate actions taken to assess and maintain the resident’s health.

Inspector #641 reviewed resident #028’s physician orders which indicated that the resident had been prescribed a specific medication to be administered at 1700 hours, and a different medication to be administered at 2000 hours

During an interview with Inspector #641 on February 8, 2018, the DOC indicated that on a specified date, RPN #111 administered the medication that had been prescribed for resident #028 for 1700 hours, at 2000 hours . The DOC indicated that the RPN recognized the error at the the end of the shift. At that time, RPN #111 completed a medication incident report, notified the SDM and physician. The RPN indicated to the DOC that because it was at the end of the shift, the RPN had not done an assessment of the resident.

During an interview with Inspector #641 on a February 9, 2018, RN #118 indicated that at the end of shift report for a specified date with RPN # 111, both recognized that RPN #111 had administered the medication prescribed for resident #028 for 1700 hours at 2000 hours . RN #118 clarified that RPN #111 completed the medication incident report, but the RN had forgotten to do an assessment of the resident and document the incident in the shift report so that on coming shifts would continue to do assessments on resident #028.

During an interview with Inspector #641, the Director of Care (DOC) #101 indicated that when a medication incident occurred, the registered staff would complete a medication incident report. If the medication incident reached the resident, the resident would be assessed immediately and for 72 hours, as was the expectation in the licensee.

The licensee failed to ensure that actions were taken to assess resident #028 following the medication incident that occurred on a specified date. [s. 135. (1)]

Issued on this 12th day of March, 2018

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

Original report signed by the inspector.