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 |
|---|---|---|---|
| Sep 25, 2018 | 2018_671684_0019 | 016346-18 | Resident Quality Inspection |

## 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 Kirkland Lake
155 Government Road East KIRKLAND LAKE ON P2N 3P4

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

SHELLEY MURPHY (684), LOVIRIZA CALUZA (687)

## 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): September 10-14, 2018.**

**The following intakes were inspected during this Resident Quality Inspection:**

**Four Critical Incidents (CIs), related to Acute Respiratory Infection (ARI) outbreaks.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Support Service Manager, Resident Program Manager (RPM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping staff, family members, and residents.**

**The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies, and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident-staff interactions.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Housekeeping**
**Continence Care and Bowel Management**
**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.**
- **4 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 57. Powers of Residents' Council**

**Specifically failed to comply with the following:**

**s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when the Residents' Council had advised the licensee of concerns or recommendations, the licensee, within 10 days of receiving the advice, responded to the Residents' Council in writing.

Inspector #684 reviewed the past quarter Resident Council meeting minutes which identified that the Resident Council had brought forth concerns/recommendations. Inspector #684 noted in three consecutive months in 2018, the Resident Council meeting minutes indicated that the residents had recommendations/concerns regarding staffing, as well they noted in their minutes for two consecutive months, cafeteria cleanliness. The Inspector reviewed the minutes and failed to identify that there was a written response from the licensee addressing these concerns/recommendations.

Inspector #684 interviewed the Resident Program Manager (RPM) #113, who was the liason for the Resident Council, regarding the licensee's response to the Resident Council minutes. RPM #113 stated that they verbally provided responses to the Resident Council based on feedback from the Administrator and or the Director of Care (DOC). They stated that written responses would come from the Administrator or DOC to the Resident Council within 10 days.

Inspector #684 reviewed the homes policy titled "Residents' Council RC-02-01-07" last updated April 2017, which stated under procedures of Administrator/Designate that they were to respond in writing within 10 days of receiving the concern or a suggestion from the Residents Council.

During an interview held with the Administrator and Inspector #684, regarding the Resident Council, the Administrator stated they reviewed the minutes and would respond within 10 days to any concerns. Inspector #684 reviewed the past three months of Resident Council meeting minutes with the Administrator where it was noted in the minutes that the residents had concerns about staffing in the home and cafeteria cleanliness. The Administrator responded to this by saying, they had talked to the RPM about this, RPM said these areas were discussed at the meeting and that the residents concerns had been addressed. Inspector #684 asked if the response to the Resident Council concerns was put in writing, the Administrator responded no, the response was not put in writing. [s. 57. (2)]

**WN #2: 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 drugs were stored in an area or a medication cart that was secured and locked.

Inspector #687 observed a medication cart left unlocked and unattended in the hallway in a resident area, for approximately 10 minutes. Registered Practical Nurse (RPN) #110 was administering medications to residents in their rooms and was not in sight of the cart. During the time the medication cart was left unattended, multiple residents were within the immediate vicinity of the medication cart.

In a review of the home's policy titled "Medication Management" last updated February 2018, it indicated under medication administration the following:
- Ensure the medication cart was locked when unattended or out of sight.

During an interview with Inspector #687, RPN #109 stated that the medication cart was supposed to be locked at all times whenever they were away from the cart.

Inspector #687 interviewed the DOC, who stated that the medication cart should be locked any time registered staff were not in attendance of the cart, to prevent harm or risk of harm to any resident. [s. 129. (1) (a)]

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**WN #3: 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.

During a review of the last quarter medication incident reports, Inspector #684 noted a medication incident report from a specified date in 2018, which documented that resident #009 received medications that were prescribed for resident #010.

Inspector #684 reviewed resident #009's Electronic Medication Administration Record (eMAR) from the specified month in which the error occurred, and confirmed that resident #009 was not ordered the medications that were noted to be administered in the Medication Incident form.

Inspector #684 reviewed the Medication Management policy RC-16-01-07, last updated February 2018, which stated the following:
-Ensure that the resident information on each medication dispenser (pouch/blister pack/vials etc.) corresponds identically with the resident's Medication Administration Record (MAR)/Electronic Medication Administration Recored (eMAR) prior to administering the medication.
-Two resident identifiers are required prior to administering medicaitons (see below),
-and Administer medications following the 8 "Rights" of medication administration:
a) Right resident,
b)Right drug,
c)Right dose,
d)Right time,
e)Right route (including need for medication to be crushed)
f)Right reason
g)Right response
h)Right documentation

During a meeting held with the DOC and Inspector #684, regarding the Medication Incident in 2018, the DOC confirmed that administration procedure for medication was not followed and caused the medication error. [s. 131. (2)]

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**WN #4: 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. (5) The licensee shall ensure that on every shift,**
**(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that on every shift, staff recorded symptoms of infection for residents and took immediate action as required.

During a review of the home's Critical Incident reports related to outbreak, Inspector #687 reviewed the line listing and identified that resident #003, #009 and #011 were included in the home's surveillance record.

A) Inspector #687 reviewed resident #003's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection in a specified month in 2018. The resident was maintained on isolation precautions for seven days.

The Inspector reviewed resident #003's health care records, specifically the documentation records regarding their symptoms of infection. The Inspector was unable to identify any record of the resident's symptoms of infection for a day shift, and two evening shifts during the seven day period. In addition, Inspector #687 was unable to identify any record of the resident's symptoms of infection for seven night shifts.

B) Inspector #687 reviewed resident #009's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection on a specified day in 2018. The resident was maintained on isolation precautions until eight days later.

The Inspector reviewed resident #009's health care records, specifically the documentation records regarding their symptoms of infection. The Inspector was unable to identify any record of the resident's symptoms of infection for four night shifts during the eight day period.

C) Inspector #687 reviewed resident #011's progress notes, which indicated that the resident had been placed on isolation precautions for a suspected infection on a specified day in 2018. The resident was maintained on isolation precautions for five more

days in 2018.

The Inspector reviewed resident #011's health care records, specifically the documentation records regarding their symptoms of infection. Inspector #687 was unable to identify any record of the resident's symptoms of infection for three night shifts.

In an interview with Inspector #687, RPN #110 stated, a resident would be placed on isolation precautions when they displayed two or more symptoms of an infection. The RPN stated that once isolated the resident's symptoms of infection were required to be monitored and recorded during each shift in the electronic resident progress notes.

In an interview with Inspector #687, the DOC stated that whenever a resident was isolated, the resident should be monitored and their symptoms recorded on each shift in the electronic progress notes by the registered staff while on isolation precautions. The DOC verified that resident #003, #009, and #011 did not have documentation completed.

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**Issued on this 27th day of September, 2018**

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

**Original report signed by the inspector.**