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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 3, 2017	2016_290551_0026	013463-16	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 MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

MEGAN MACPHAIL (551), JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 31, November 1, 2, 3, 4, 7 and 8, 2016.

The following logs were inspected: 026315-16 (related to a resident's fall) and 017972-16 (related to a previously issued compliance order).

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, Personal Support Workers, Registered Nursing Staff, a Pharmacist, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2016_286547_0012	550

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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

As per O. Reg 79/10, s. 136. (2) 1. The Drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

On November 4, 2016, Inspector #550 observed in the fourth drawer of the 3rd floor north wing medication cart, a small orange plastic bin containing many packs of medication containing pills, vials containing pills and loose pills. RPN #104 indicated to the inspector that these were all medications that were not administered to residents because they were either discontinued, the resident refused or was not there, etc. She further indicated that each nurse who does not administer a medication to a resident is responsible for removing the medication from the medication cart and storing it in the medication room until destruction.

Inspector #550 reviewed the home's policy titled "Drug destruction and Disposal" # 5-4, dated January 2014. Page 2 of 6 indicated under procedure:
4. Medications for destruction are removed from all medication storage areas and retained in a secure area in the medication room, separate from medications for administration to a resident, until such time as they are transferred to the designated Stericycle box/container for destruction and disposal. A surplus medications log (Drug Destruction and Disposal Log for Non-narcotic and Controlled Medications) may be used to track the additions to the box as per specific home policy.

During an interview on November 4, 2016, the Director of Care (DOC) indicated to the inspector that medications to be destroyed are to be removed from the medication cart and stored in the medication room separate from the medication for administration. The DOC removed the orange plastic bin from the medication cart and indicated that each nurse is responsible to remove the medication from the cart when they are not administered for whatever reason and storing it in the medication room. No medication to be destroyed shall be kept in the medication carts. [s. 8. (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 the drug destruction and disposal policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential care areas are:
• Equipped with locks to restrict unsupervised access to those areas by residents, and
• Locked when they are not being supervised by staff.

On October 31 and November 03, 2016, Inspector #550 observed the following non-residential care areas to be unlocked and/or opened:

3rd floor:

West wing:
''Storage room'' (clean utility) door was not locked, and there was no call bell inside. There were disposable razors in a basket on a shelf.

South wing:
''Isolation room'' (storage room) door was not locked, and there was no call bell inside. There were disposable razors in a basket on a shelf.

The servery door was not locked. Inside the cupboard under the sink there was one opened bottle of Oasis 146 Multi Quat liquid sanitizer – labelled ''Do not drink'' and one bottle of Neutral Disinfectant cleaner. On the counter there was a hot water dispenser that was hot to touch (October 31 only).

2nd floor:

North wing:
''Soiled utility'' door was not closed properly, it was kept open by the door's latch. There was no call bell inside.

South wing:
''Isolation room'' (clean utility room) the door was not locked, and there was no call bell inside. There were disposable razors in a basket on a shelf.

The servery door was not locked. On the door there was a sign indicating ''keep closed and locked at all times for safety and sanitation''. Inside the servery, the steam table was hot to touch and was filled with steaming hot water. In the cupboard under the sink, there was a bottle of Oasis 146 Multi Quat liquid sanitizer. Inside the second drawer, there was a sharp knife (October 31 only).

1st floor:

West wing:
The clean utility door was not locked, and there was no call bell inside. There were many disposable razors on a shelf and a bottle of Disinfectant cleaner IV.

During an interview, the Administrator, the Director of Care and the Assistant Director of Care indicated to the inspector that all the storage rooms including the isolation rooms, utilities and serveries are defined as non-residential care areas and are to be kept closed and locked at all times. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents and are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances are labelled properly and kept inaccessible to residents at all times.

On October 31, 2016 Inspector #550 observed the following hazardous products in various locations:

• On the third floor, the servery door was unlocked. Inside the cupboard under the sink there was one opened bottle of Oasis 146 Multi Quat liquid sanitizer labelled ''Do not drink'' and one bottle of Neutral Disinfectant cleaner. In the west wing storage room, there was a bottle of Disinfectant Cleaner IV on a shelf.
• On the second floor north wing, the ''Soiled utility'' door was not closed properly; it was kept open by the latch. Inside there was a bottle of Neutral Disinfectant cleaner.
• On the second floor, the servery door was unlocked. Inside the cupboard under the sink, there was a bottle of Oasis 146 Multi Quat liquid sanitizer.
• On the first floor west wing, the clean utility door was not locked. Inside there was a bottle of Disinfectant cleaner IV.

During an interview with the Administrator on November 8, 2016, she indicated that all the above products are hazardous products and should be kept locked at all times. [s. 91.]

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 hazardous substances are labelled and kept inaccessible to residents at all times, 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 drugs are stored in an area or a medication cart,

(ii) that is secure and locked.

On October 31, 2016, on the second floor south wing, Inspector #550 observed a medication cart in the hallway unattended, and residents were wandering in the hallway. The medication cart was locked, but on top of the medication cart there was one bottle of a specific medication belonging to resident #021, one bottle of a specific medication belonging to resident #022 and one bottle of Potassium Chloride from stock medication. A PSW nearby indicated that the RPN was in the nursing station in the west wing and called her by phone at the inspector's request. When RPN #101 arrived at the medication cart where the inspector was waiting, she indicated to the inspector that she had forgotten to put the medication bottles back in the medication cart before she left the cart. She indicated that it was not her practice to leave medications on top of the cart unattended.

During an interview on November 4, 2016, the Administrator, the Director of Care and the Assistant Director of Care indicated to the inspector that they had been made aware of the incident and that the DOC had already met with RPN #101. They indicated that all medications are to be stored inside the medication cart at all times, and that the medication cart is to be kept locked when it is unattended. [s. 129. (1) (a)]

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 stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was monitoring and documentation of the resident's response and the effectiveness of the drug.

Resident #001 was admitted to the home in 2014 and has several medical diagnosis. On November 2, 2016, the resident reported to Inspector #550 that he/she was in constant pain. Resident #001 is prescribed several medications to treat his/her conditions.

During a specified month, resident #001 received the following as necessary/pro re nata (prn) medications:

A specified medication: twenty seven times.
A specified medication: twenty nine times.

The effectiveness of the prn drug is coded on the medication administration record (MAR) as I (Ineffective), E (Effective) or U (Unknown) according to the legend for follow up codes.

The home`s policy titled PRN Medications (RC-06-05-14) states that the Nurse administering the PRN medication will assess the Resident prior to administration of the prescribed medication and the assessment will be documented. The policy states that the progress notes may be used to document the effectiveness of the PRN given.

The pharmacist stated that each time a prn medication is given, a Medication Administration Note is auto-populated to the progress notes and is to be filled in by the nurse administering the prn. Each of the days during a specified month when the resident's response and the effectiveness of the drug was coded as U were reviewed with the pharmacist, and the following was noted:

On a specified date, the resident received two medications at 1404 for generalized pain. The effectiveness of the medications is coded as U on the MAR, and there was no documentation addressing the effectiveness of the drugs. The resident received an additional dose of a specific medication at 2049. The effectiveness is coded as I. There is no documentation indicating why the drug was given at 2049 or what was done when the drug was ineffective.

On a specified date , the resident received two medications at 1254 for pain. The effectiveness of the medications is coded as U on the MAR, and no additional progress notes were written on this day in the resident's chart.

On a specified date, the resident received two medications at 2034. The Medication Administration Note is blank and does not indicate why the drugs were given. The effectiveness of the medications is coded as U on the MAR, and no additional progress notes were written on this day in the resident's chart.

On a specified date, the resident received two medications at 2119, and the reason for administering the drugs according to the Medication Administration Note was "upon request". The effectiveness of the medications is coded as U on the MAR, and no additional progress notes were written on this day in the resident's chart.

On a specified date, the resident received a medication at 2031, and the effectiveness is

coded as U on the MAR.

On a specified date, the resident received two medications. The MAR is signed at 1410 and 1409, respectively. Medication Administration Notes stated that the specific medication was given at 1300 for general pain, and that the other medication was given for a specific pain. The effectiveness of the medications is coded as U on the MAR, and no additional progress notes were written on this day in the resident's chart.

On three specified dates, the resident received two medications at 2029, 2026 and 2029, respectively. In the three instances, the Medication Administration Notes are blank and do not indicate why the drugs were given. In the three instances, the effectiveness of the medications is coded as U on the MAR, and no additional progress notes were written in the resident's chart on these days.

In an approximate one week period during a specific month, resident #001 received a specific prn medication three times, and another specific prn medication twice.

On two specific dates, the Medication Administration Notes are blank and do not indicate why the drugs were given. On both days, the effectiveness is coded as U on the MAR, and there was no documentation addressing the effectiveness of the drugs.

On a specified date, the resident received a medication at 2155 for pain. The effectiveness is coded as U on the MAR, and no additional progress notes were written on this day in the resident's chart.

The pharmacist stated that the effectiveness of the pain medication should be assessed one hour after its administration.

During a period of approximately five weeks, the resident's response and the effectiveness of the drug was not documented eleven times following the administration of prn doses of a specific medication and eleven times following the administration of prn doses of another specific medication. [s. 134. (a)]

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 there is monitoring and documentation of the resident's response and the effectiveness of prn medications, to be implemented voluntarily.

WN #6: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the SDM, if any, and the designate of the resident / SDM been provided the opportunity to participate fully in the development and implementation of the plan of care.

Log #026315-16.

On a specified date, a CIS report was submitted to the Director reporting that resident #023 had a fall and required to be transferred to the hospital the following day. One day prior, the home was made aware by the resident's family member that the resident had sustained a specific diagnosis.

On the CIS report, it was documented by the ADOC that the resident's family was not contacted when the resident was transferred to the hospital. Documentation in the progress notes indicated that on a specified date, the home received a call from the resident's family member who indicated being very upset because she had not been notified by the home that her family member had been transferred to the hospital or had had a fall. The family member indicated that she found out when she received a call from the hospital. A note in the progress notes by the ADOC on a specified date indicated that the resident's family member informed her that it was the second time that resident #023 was sent to the hospital and that the family was not notified.

During an interview with the ADOC on November 7, 2016, she indicated to the inspector that family members have to be notified when a resident is transferred to the hospital by the registered staff who is transferring the resident, and that resident #023's family had not been contacted by the nurse when the resident was transferred to the hospital.

During an interview with RN #105 on November 7, 2016, she indicated that she transferred the resident to the hospital at the end of her shift and that she had asked the evening nurse to contact the resident's family, but she had not documented this anywhere or followed up on it.

Inspector #550 reviewed the resident's health care records with the ADOC and observed the name and telephone number for two emergency contact persons. The ADOC indicated that these are the two emergency contact persons for resident #023 and that either one should have been informed when the resident was transferred to the hospital. [s. 6. (5)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff applied the physical device that has been ordered or approved by a physician.

Resident #008 was admitted to the home in 2014 with specific diagnosis.

On November 1, 2016, two short bed rails were noted on resident #008's bed.

A review of the resident's health care record indicated that on a specified date the physician ordered full bedrails when in bed for safety purposes. Verbal consent to the use of full bedrail restraints had been obtained from the resident's SDM one day prior.

The most recent Medication Review Report signed by the physician included an order for Restraints: Full bedrails while in bed for safety purposes.

A progress note entry on a specified date written by RN #103 stated that resident #008 was opposed to full bedrails. The progress note indicated that the resident consented to the use of half bedrails and other fall prevention strategies, and that the SDM had been updated.

RN#103 stated that the order for full bedrails as a restraint had been missed on the medication reviews and should have been discontinued.

The home's policy titled Physical Restraints (RESI-10-01-01) states that the restraint order is to be reassessed and reordered every three months as part of the quarterly medication and treatment review. [s. 110. (2) 1.]

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Issued on this 4th day of January, 2017

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

Original report signed by the inspector.