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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 22, 2019	2018_665551_0003	009823-18, 009838-18, 013299-18, 013577-18	Complaint

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 Medex
1865 Baseline Road OTTAWA ON K2C 3K6

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

MEGAN MACPHAIL (551)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 25, 26 and 31 and November 1, 2 and 5, 2018.

The following logs were inspected:
- 13577-18 and 13299-18 related to concerns about the care of a resident.
- 009823-18 and 009838-18 (Critical Incident System (CIS) # 2579-000023-18) related to an allegation of resident to resident sexual abuse.

- the finding issued under r. 8 for log 027346-18 / CIS 2579-000042-18 is included in this report.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers, Registered Nursing Staff, a Recreation Worker, the Social Worker, the Registered Dietitian, the Laundry Valet, the Physiotherapist, the Program Manager, the Maintenance Manager, the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Falls Prevention
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 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 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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or put in place any policy, the policy was complied with.

Under O. Reg 79/10, s. 52, the licensee is required to have a pain management program, and as per O. Reg 79/10, s. 8, the licensee is required to comply with the program.

The licensee's Pain Identification and Management policy (RC-19-01-01) states that all residents have the right to and will be offered the best pain relief possible.

The Procedures section of this policy directs the nurse to: 1. residents will be assessed for pain using the Pain Flow Note in PCC for any specific criteria including: re-admission, resident states they have pain, any change in condition that has the potential to impact the resident pain level, taking new pain-related medication for < 72 hours, taking an increased dose and/or frequency of pain-related medication, family/staff/volunteer indicate that the resident has verbalized or has expressed non-verbally that they are experiencing pain.

On admission, resident #001 was prescribed specified pain medications administered at specific intervals daily and as needed.

On a specified date, the dosage of a specified pain medication was decreased.

In a progress note entry eleven days later, the physician noted that resident #001 was complaining of increased pain to a specified body part. The physician ordered that the dosage of the specific pain medication that had been decreased, be resumed, and

increased the order for the resident's other pain medication.

During a specified time, resident #001 was hospitalized. According to a hospital discharge record, resident #001 received a specified pain medication prior to discharge.

Upon return from hospital, medication reconciliation was completed, and new pain medication was ordered.

A review of the resident's Medication Administration Record (MAR) and progress notes, indicated that:
- Following the resident's return from hospital, the first dose of a specified pain medication was administered approximately eight hours later when the resident was awake to use the washroom.
- Two days after returning from hospital, the physician increased the dosage of the regular pain medication and the pain medication to be given as needed.

Despite meeting the criteria as specified in the policy above, a review of the resident's health care record indicated that the resident was not assessed for pain using a Pain Flow Note, including, when:
- the physician resumed the dosage of a specified pain medication and noted that the resident was complaining of pain
- upon readmission from hospital, including:
- when the resident did not receive pain medication for approximately eight hours
- when the resident's dosage of specified regular and as needed pain medications were increased on specified dates.

(logs 13577-18, 13299-18) [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has 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 policy was complied with.

The licensee's Pain Identification and Management policy (RC-19-01-01) states that all residents have the right to and will be offered the best pain relief possible.

The Procedures section of this policy directs the nurse to: 1. Assess residents for pain using the Pain Flow Note in PCC (if resident is non-verbal or cognitively impaired, use the PAINAD, Appendix 4) to assist in completing the note. There is a list of criteria for

completing the Pain Flow Note including: any change in condition that has the potential to impact the resident pain level, distress either physical or emotional related to behaviours, family/staff/volunteer indicate that the resident has verbalized or has expressed non-verbally that they are experiencing pain. Under the Documentation section of this policy, it states that 2. Care staff will provide pain management interventions within their scope of practice.

On a specified date, during the provision of care, resident #004 was left unattended and rolled out of bed and onto the floor.

In a Post Fall Assessment completed after the fall, it was noted that the resident's range of motion was adequate, and that there were no visible injuries, pain or discomfort.

As part of post fall monitoring, resident #004's pain was monitored. The resident's pain was recorded as 0 on specified dates at specified times.

On the day after the fall, RPN #108 charted that the resident's pain level was 4.

On November 2, 2018, RPN #108 was interviewed and stated that the resident was acting different from their baseline condition. With regards to the assessment on the specified date, one day after the fall, the RPN stated that the findings were reported to the physician and RN #123 who were both in the nursing station and that a progress note was written

On the day after the fall, the physician wrote a progress note and stated that resident #004 was acting different from their norm and upon examination, the resident appeared to have pain.

The physician ordered a portable x ray of specific body parts and a specified pain medication every 2 hours as needed.

A review of the progress notes indicated that resident #004's pain was not assessed using a Pain Flow Note when the resident's pain scale was recorded as being 4 on the day after the fall.

A review of the resident's MAR indicated that resident #004 was never administered the specified pain medication as needed. The MAR also indicated that that a regularly scheduled analgesic was not administered at at specified time on the day after the fall.

"9/Other/See Nurse Notes" is coded by RPN #108, however there was no progress note entry written by RPN #108 on that shift.

Several days after the fall, it was revealed that resident #004 had a specific injury and was sent to hospital. During the hospitalization, the resident developed complications and passed away.

In an interview with the DOC, they stated that pain management, including the administration of pain medication as needed was within the RPN scope of practice.

The licensee did not comply with the Pain Identification and Management policy in that resident #004 was not assessed for pain using the Pain Flow Note in PCC on the day after the fall when the resident's pain was recorded as 4, and the resident was not offered pain management interventions.

(log 027346-18/ CIS 2579-000042-18) [s. 8. (1) (a),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 Pain Identification and Management policy is complied with, 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 are administered to the resident in accordance with the directions for use specified by the prescriber.

Two days after the resident returned from hospital, the physician increased resident #001's order for specified pain medications.

According to the MAR, this was implemented the following day at 0001 hours.

According to the MAR, resident #001 did not receive two doses of a specified medication on a specified date as ordered.

(logs 13577-18, 13299-18) [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 the resident 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. 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 is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

On October 25, 26 and 31, and November 1 and 2, 2018, the door to the Conference Room on the first floor of the home was noted to be open and unlocked.

The room is accessible to residents as was confirmed through observation and by the Administrator.

There is no resident-staff communication and response system available in this area that is accessible by residents. [s. 17. (1) (e)]

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The person who had reasonable grounds to suspect that abuse of a resident by anyone failed to immediately report the suspicion and the information upon which it was based to the Director.

On a specified date, Critical Incident Report (CIR) 2579-0000023-18 was submitted to the Director, under LTCHA, s. 24 to report an allegation of sexual abuse involving resident #003 and resident #002. As per the CIR, the incident had occurred four days earlier.

In an interview with PSW #119, they indicated that they witnessed resident #003 touching resident #002 on a specified body part, and resident #002 was yelling and trying to remove resident #003's hand. According to PSW #119, the incident was reported to RPN #124.

RN #123 was interviewed and stated that RPN #124 did report that a PSW had reported that resident #003 was in resident #002's room and was touching the resident near a specified body part.

On a specified date, RN #123 wrote a progress note entry in resident #003's chart stating that the resident was seen inappropriately touching resident #002 in resident #002's room.

The Director was not notified of the allegation immediately; the Director was notified until four days later when the CIR was submitted.

(logs 009823-18, 009838-18 / CIS 2579-000023-18) [s. 24. (1)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's SDM and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.

On a specified date, resident #003 was found by PSW #119 in resident #002's room and was touching resident #002 on a specified body part. According to the PSW resident #002 was yelling and trying to remove resident #003's hand.

RN #123 was interviewed and stated that RPN #124 did report that a PSW had reported that resident #003 was in resident #002's room and was touching the resident near a specific body part.

Resident #002's SDM was not notified of the incident of alleged abuse until several days later.

(logs 009823-18, 009838-18 / CIS 2579-000023-18) [s. 97. (1) (b)]

Issued on this 8th day of February, 2019

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

Original report signed by the inspector.