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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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 28, 2019 | 2019_505103_0002 | 003411-18, 006416-18, 011045-18, 012677-18, 013898-18, 014637-18, 019537-18, 024717-18, 025976-18, 027644-18, 027916-18, 029014-18, 029991-18, 031355-18 | 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 Medex
1865 Baseline Road OTTAWA ON K2C 3K6

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

DARLENE MURPHY (103)

## 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): January 14-18, 21-24, 2019.**

**Log #003411-18 (CIS #2579-000009-19), Log #029014-18 (CIS #2579-000045-18), and Log #031355-18 (CIS #2579-000047-18)-alleged incidents of staff to resident abuse/neglect.**

**Log #027916-18 (CIS #2579-000043-18)-alleged incident of improper/incompetent resident care.**

**Log #024717-18 (CIS #2579-000037-18)-unexpected death.**

**Log #027644-18 (CIS #2579-000006-18)-missing controlled substance.**

**Log #011045-18 (CIS #2579-000025-18), Log #012677-18 (CIS #2579-000027-18), Log #019537-18 (CIS #2579-000036-18), Log #025976-18 (CIS #2579-000038-18), and Log #029991-18 (CIS #2579-000046-18)-incidents of resident falls that resulted in injury.**

**Log #006416-18 (CIS #2579-000017-18), Log #013898-18 (CIS #2579-000028-18), and Log #014637-18 (CIS #2579-000030-18)-incidents of alleged resident to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.**

**During the course of this inspection, the inspector reviewed resident health care records, observed resident care, reviewed applicable policies and the home's investigation into alleged incidents of abuse.**

**The following Inspection Protocols were used during this inspection:**

**Falls Prevention**
**Hospitalization and Change in Condition**
**Medication**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Safe and Secure Home**

**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<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 | Légende<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. 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).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the care set out in resident #008's plan of care was provided to the resident as specified in the plan.

On an identified date, resident #008 sustained an injury while being assisted into bed by a PSW. The resident's plan of care, in effect at the time of this incident, indicated the resident was prone to injury as a result of fragile skin integrity. Under "transfer" the plan of care indicated the resident was to receive the extensive assistance of two staff and the use of a sit to stand lift.

RPN #105 and RN #106 were interviewed and both reported the PSW had transferred the resident into bed without the assistance of another staff member or the sit to stand lift. RN #106 stated the PSW was new to the home and had stated they had not referenced the resident transfer logo prior to completing resident #008's transfer. RN #106 stated the resident reported having pain in the area when they were assessed. At the time of this inspection, the injury was healed. [s. 6. (7)]

2. The licensee has failed to ensure the care set out in resident #009's plan of care was provided to the resident as specified in the plan.

On an identified date on or about 0630 hour, resident #009 was found by PSW #104 with dried feces on both legs. This PSW was interviewed and stated with help from PSW #108, they assisted resident #009 into the shower. Following the shower, PSW #104 stated the resident's bed and floor were also found to be covered in dried feces. PSW #104 stated they had never found the resident like this before. PSW #104 reported their

concerns to RN #101.

Resident #009's plan of care, at the time of this incident, indicated the resident wore a continence product and required one staff to check and manage.

ADOC #103 was interviewed and indicated the home investigated the incident and interviewed PSW #100 who had been assigned to resident #009 during the night shift. The ADOC stated PSW #100 indicated they had not provided care to the resident during the shift and they had not reported this to the night charge nurse. [s. 6. (7)]

3. The licensee has failed to ensure the care set out in resident #017's plan of care was provided to the resident as specified in the plan.

On an identified date, resident #017 was found with injuries. RPN #109 was working on the resident's home area on that date and was interviewed. RPN #109 indicated they heard resident #017 shouting and entered the room. The RPN indicated two PSW's were attempting to complete a treatment and the resident was trying to pull away and shouting "stop doing that". RPN #109 stated they tried to calm the resident down without effect and eventually the treatment was completed. The RPN indicated they knew the resident well and that sometimes the resident would continue to resist even if reapproached.

RN #106 was interviewed and indicated they were the charge nurse on evenings. The RN reported a PSW told them at the beginning of their shift they had observed three staff members from the previous shift huddled around resident #017. The PSW told RN #106 they were alerted to the room as they heard the resident shouting. The PSW stated the resident was resisting and calling out.

RN #106 stated they went to assess resident #017 who appeared to be in pain and was initially resistant to having the RN assess them. RN #106 indicated they reassured the resident, the resident calmed and they were eventually able to complete the assessment. RN #106 stated resident #017 had a cognitive impairment and was known to be resistant to care. The RN stated the resident required a gentle persuasive approach and that the care should have been stopped when the resident began to resist.

Resident #017's plan of care, in effect at the time of this incident, was reviewed. Under "behaviours", the care plan indicated if refusing to reapproach in thirty minutes to an hour and to attempt to distract the resident with conversation.

RN #106 contacted the physician and provided resident #017 with treatment. Resident #017's future treatments were assigned to be completed by the behavioural support staff only. [s. 6. (7)]

4. The licensee has failed to ensure the care set out in resident #001's plan of care was provided to the resident as specified in the plan.

On an identified date, resident #001 reported they had been allegedly abused by RN #111 to the DOC. The resident reported the RN had yelled at them and given them a needle. The resident reported RN #111 was the only one to give the resident needles. The resident also indicated while RN #111 administered the needle, the RN twisted their arm.

Resident #001's health care record was reviewed including an identified electronic medication administration record (eMAR). The resident had an identified medication prescribed which could be administered by mouth or by injection. On two identified dates, the eMAR indicated RN #111 had administered the identified medication by injection and indicated in both instances that the medication had been ineffective. The resident progress notes were reviewed and there was no documentation to support the resident had refused to take the identified medication by mouth. Resident #001's eMAR's were reviewed for a period of three identified months. There were no additional instances for which resident #001 had been given the identified medication by injection.

RPN #115 was interviewed and indicated the resident was to receive the identified medication by injection only if resident #001 was refusing to take the medication by mouth. The RPN further indicated resident #001 took the medication by mouth without any problems. RPN #115 indicated they recalled incidents whereby RN #111 many months ago had administered the identified medication by injection even when the resident was taking the oral medication.

DOC #114 was interviewed and indicated they had been involved in the investigation into this alleged abuse. The DOC stated the identified medication was ordered to be given by injection only if the resident refused to take it by mouth. The RN no longer works in the home. [s. 6. (7)]

5. The licensee has failed to ensure resident #013 was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

On an identified date on or about 0800 hour, resident #013 reported to staff they had fallen when out of the home the previous day and was reporting pain in a newly identified area.

The following day, staff reported the resident had increased difficulty transferring and required the use of a mechanical lift and 2 staff. Three days later, resident #013 fell while being transferred by a staff member. According to the documentation in the resident's health care record, the resident became weak and shaky during the transfer and was lowered to the floor by the staff. The physician was notified and an x-ray was ordered which later revealed an identified injury which required the resident's transfer to hospital.

Resident #013's medication administration record for an identified month was reviewed and indicated the resident required an analgesic (ordered on an as needed basis) on three occasions during this time frame. Two out of the three doses given were documented as being ineffective. No documented assessments were found related to the resident's pain or change in ability to transfer as a result of the resident's report to staff of a fall.

ADOC #103 and DOC #114 were both interviewed in regards to this incident. DOC #114 indicated resident #013 prior to this incident had been transferring with the supervision of one staff member and had previously reported pain, but not in the newly identified area. The DOC indicated the resident's condition had changed from their previous baseline and staff should have completed an assessment in an effort to determine the reason for the change. [s. 6. (10) (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 resident #008, #009 and #017 receive care as specified in the plans of care and to ensure resident #013 is reassessed when the resident's care needs change, to be implemented voluntarily.***

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**WN #2: 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. A person who had reasonable grounds to suspect the improper or incompetent treatment of resident #017 that resulted in harm to the resident failed to report the suspicion and the information upon which it was based immediately to the Director (MOHLTC).

As outlined in WN #1, on an identified date on or about 1430 hour resident #017 sustained injuries as a result of staff members attempting to complete a treatment. The home submitted a critical incident report (CIR) #2579-000043-18 on an identified date to report the incident.

RPN #109 was interviewed and stated at the time, they did not believe the incident was reportable. RN #106 was interviewed and indicated they believed this incident did constitute an incident of incompetent care. The RN indicated they immediately contacted the Administrator who was still present in the home and requested they come to see the resident. RN #106 stated they then notified the physician and the POA of the incident. RN #106 indicated the Administrator had stated they would notify the ministry of the incident.

The Administrator was interviewed and stated they recalled the incident and had gone up to see resident #017 on or about 1830 hour. The Administrator indicated they considered the incident reportable as an incident of improper or incompetent care. They indicated

they were aware RN #106 had notified both the physician and the POA and thought the RN would also be contacting the MOHLTC after hours pager to report the incident. The Administrator indicated there must have been a miscommunication between themselves and the RN and indicated the CIR, submitted the day after the incident, was the means by which the ministry was first notified of the incident. [s. 24. (1)]

2. A person(s) who had reasonable grounds to suspect the abuse of resident #001 that resulted in risk of harm to the resident failed to report the suspicion and the information upon which it was based immediately to the Director (MOHLTC).

As outlined in WN #1, on an identified date, resident #001 reported an allegation of abuse to the management team involving RN #111. The home conducted an immediate investigation into the allegations and submitted a critical incident report (CIR) #2579-000009-18 two days later to report the incident. PSW #116 and RPN #115 were interviewed and indicated they had been aware of inappropriate actions involving RN #111 on the evening prior to the resident coming forward with the complaint, but both reported they failed to report the actions to anyone because they feared retaliation by RN #111.

DOC #114 was interviewed and indicated the CIR was the means by which the ministry was notified of the alleged abuse. The DOC indicated the late reporting was an oversight. [s. 24. (1)]

***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 all incidents of alleged abuse and improper or incompetent treatment of a resident is immediately reported to the Director, to be implemented voluntarily.***

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**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 has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg 79/10, s. 114 (2), the licensee failed to ensure the written policy to ensure the accurate acquisition of all drugs stored in the home was complied with.

Specifically, staff failed to comply with the licensee's policy regarding "Management of Narcotic and Controlled Drugs, #RC-16-01-13", which was last updated February 2017. This policy states, "two nurses, one from the outgoing shift and one from the incoming shift, will count and sign-off on the Narcotic and Controlled Substances Count Sheet every shift change."

On the morning of an identified date, the DOC was informed of a discrepancy in the count for injectable dilaudid. The DOC was interviewed and indicated they investigated the discrepancy and discovered a shift count had not been completed that morning between the off-going night RN and the on-coming RPN.

According to the DOC, RPN #109 completed an independent count on or about 0730 hour and reported the discrepancy to RN #112. RN #112 confirmed the discrepancy and reported to the DOC. The DOC indicated the count had been correct when checked by the registered staff during the evening/night shift count. The DOC was able to verify the dilaudid had not been administered during the night shift and was unable to account for the discrepancy.

The DOC indicated there have been no additional instances of unaccounted for controlled substances. [s. 8. (1) (b)]

**Issued on this 28th day of January, 2019**

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

**Original report signed by the inspector.**