Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Nov 18, 28, 2019	2019_665551_0022	013808-19, 014288-19, 014298-19, 017912-19, 018922-19	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

MEGAN MACPHAIL (551)

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): October 7, 8, 9, 10, 11, 16, 17 and 18 and November 14 and 15, 2019.

The following logs were inspected:
013808-19 / Critical Incident Report 2579-000029-19 related to the fall of a resident.
014298-19 / Critical Incident Report 2579-000030-19 related to the fall of a resident and an allegation of staff to resident neglect.
014288-19 / Critical Incident Report 2579-000031-19 related to an allegation of resident to resident abuse.
017912-19 / Critical Incident Report 2579-000035-19 related to the fall of a resident.
018922-19 / Critical Incident report 2579-000038-19 related to the unexpected death of a resident.

During the course of the inspection the inspector(s) reviewed health care records and selected policies and procedures, and observed staff to resident and resident to resident interactions.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), a Behavioural Supports Ontario (BSO) PSW, Registered Nursing Staff, the Wound Care Champion, an Activity Aide, the Assistant Directors of Care, the Director of Care and the Administrator.

During the course of the inspection, the inspector(s) reviewed health care record and selected policies and procedures and observed staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **5 WN(s)**
- **4 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 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 has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

According to a review of resident #001's plan of care:

i) On a specified date at a BSO Team meeting, it was discussed that items should not be taken away from resident #001 without providing a trade for them.

A progress note entry on a specified date indicated that resident #001 was carrying a bag of clothing, and a PSW grabbed the bag from the resident. The resident reacted responsively and grabbed the PSW.

In an interview with Activity Aide #115, they stated that resident #001 was walking with a bag of clothing, and PSW #112 grabbed the bag and was tugging on it. As per the Activity Aide, the resident responded by grabbing the PSW. According to the Activity Aide, a few minutes later, a different staff member was seen doing tug of war with a coat and resident #001.

ii) On a specified date, a progress note was written that indicated that resident #001 was holding a fork and pointed it at a PSW with an angry expression. According to the progress note, the PSW took the fork from the resident, and the resident responded responsively and grabbed the PSW.

Resident #001 was not offered a trade for the bag of clothing or the fork as indicated in their plan of care.

iii) The physician orders for resident #001 directed staff to give the resident a specific medication on an as needed basis for severe agitation or aggression and to administer a

second type of as needed medication, if the first one was not effective.

On a specified date, resident #001 was given the first type of as needed medication by RPN #106 following an altercation with resident #002.

As per RN #104, following the incident between resident #001 and resident #002, a code was called, and they contacted the on call physician who authorized a transfer to hospital. As per the RN when the paramedics arrived, they asked why they were taking resident #001 to hospital as they were calm at the time.

According to RPN #106, the administration of the first type of as needed medication was effective, and resident #001 did not require the administration of the second type.

Resident #001 was sent to hospital for assessment after the administration of the first type of as needed medication was effective, and the second type was not administered as per their plan of care.
[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 to resident #001 as specified in the plan, to be implemented voluntarily.

WN #2: 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 required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with.

The licensee was required to ensure that in accordance with O. Reg 79/10, s. 48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: Falls Prevention and Management.

Specifically, staff did not comply with the licensee's Post Fall Management procedure which is part of the licensee's Falls Prevention and Management Program (RC-15-01-01).

The Post Fall Management procedure directs staff to: FOR 72 HOURS, POST FALL
1. Assess the following at each shift:
a. Vital signs;
b. Pain;
c. Bruising
d. Change in functional status
e. Change in cognitive status; and
f. Changes in range of motion.
4. Document the fall and results of all assessments and actions taken during the 72-hour post-fall follow up.

The licensee's FALLS MANAGEMENT - Clinical Monitoring Record - V 3, a neurological check completed every eight (8) hours includes an assessment of the following: vital

signs, pain, pupils, Glascow coma scale and motor responses.

On a specified date, resident #004 fell and was sent to the hospital. Before being transferred to the hospital, the resident's vitals signs were not assessed (vital signs from a different date were noted in the Post Fall Assessment).

Upon return from hospital, neurological checks every 8 hours were initiated. A neurological check was not recorded on two (2) night shifts and one (1) day shift that were within 72 hours of the fall.

2. On a specified ate, resident #007 fell and was sent to hospital.

Upon return from hospital, neurological checks every 8 hours were initiated. A neurological check was not recorded on 1 day shift that was within 72 hours of the fall.

3. On a specified date, resident #006 fell and was sent to hospital.

Upon return from hospital, neurological checks every 8 hours were initiated. A neurological check was not recorded on 1 evening and 2 night shifts that were within 72 hours of the fall.

In an interview with the DOC, they indicated that the Post Fall Monitoring should be completed for 72 hours as directed by the procedure.

Staff did not comply with the licensee's Post Fall Management procedure related to neurological checks post fall for resident #004, resident #007 and resident #006. [s. 8. (1) (a),s. 8. (1) (b)]

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

In accordance with O. Reg, 48 (1) the licensee was required to ensure that the following interdisciplinary programs are developed and implemented in the home: Skin and Wound Care.

Specifically, staff did not comply with the licensee's Wound Care Management procedure which is part of the licensee's Skin and Wound Program (RC-23-01-02).

The Administrator provided the inspector with a copy of the licensee's Skin and Wound Program. The Skin and Wound Program: Wound Care Management procedure directed staff to
1. Document all skin breakdown in the interdisciplinary progress notes (or wound progress note), and where required, in surveillance tools.
2. Initiate one assessment tool for each open area/wound.
3. Complete the assessment tool if condition is worsening or not improving as expected, but minimum every 7 days.

In an interview with the DOC, they indicated that the surveillance tools, referred to in the procedure, were the electronic forms in Point Click Care titled Skin - Weekly Impaired Skin Integrity Assessment - V 4 (Skin Integrity Assessment) for all bruises, tears and scratches, and the Skin - Weekly Wound Assessment - includes Bates-Jensen - V 8 (Wound Assessment) for all pressure ulcers. In an interview with the Wound Care Champion, they indicated that the Weekly Skin Integrity and Wound Assessments were completed by any member of the registered nursing staff, and that one assessment was completed for each area of altered skin integrity weekly or sooner if there was a deterioration in the wound.

Upon review of resident #004's health care record, it was noted that resident #004 had impaired skin integrity.

i) On a specified date, a progress note indicated that resident #004 had sustained altered skin integrity to a specified body part. A Skin Assessment was not completed for the altered skin integrity when it was sustained or anytime there after.

ii) On a specified date, a Skin Assessment was completed for an area of altered skin integrity. A referral was completed by the the Wound Care Champion who noted that the resident had been receiving treatment for the issue for several months. According to the electronic Treatment Administration Record (eTAR), the issue resolved approximately 2 weeks later. Between the completion of the Skin Assessment and when the issue resolved, a weekly assessment was not completed.

iii) On a specified date, a Skin Assessment was completed for a new skin issue to a specified body part. A treatment was initiated on the eTAR. Following the initial assessment, a weekly one was not completed.

iv) On a specified date, a Skin Assessment was initiated for a new skin issue to a specified body part. A treatment was initiated on the eTAR. Following the initial assessment, a weekly one was not completed.

v) Four days after resident #004 fell, to observe the areas of altered skin integrity daily, until resolved, was initiated on the eMAR. A Skin Assessment was never completed on the areas of skin impairment.

vi) On a specified date, a progress note was written indicating that resident #004 had a new area of altered skin integrity. A Wound Assessment was not completed on the area of skin impairment.

vii) On a specified date, a progress note was written indicating that resident #004 had four (4) new areas of altered skin integrity. A Wound Assessment was not completed on these areas of skin impairment.

viii) On a specified date, a progress note was written indicating that resident #004 had three (3) new areas of altered skin integrity. A Wound Assessment was not completed on these areas of skin impairment.

5. i) A Head to Toe Assessment was completed when resident#009 was admitted to the home, and 3 areas of altered skin integrity were noted. A Skin or Wound Assessment was not completed on the areas of altered skin integrity that were noted on admission or anytime there after. According to the eTAR and progress notes, a treatment to a specified body part was initiated and discontinued approximately 1 month later.

ii) On a specified date, a Wound Assessment was completed for an area of altered skin integrity, and a treatment was initiated on the eTAR. Following the initial assessment, a weekly one was not completed, and a treatment remained on the eTAR at the time of the inspection.

iii) A progress note written on a specified date indicated that resident #009 had a new area of altered skin integrity. A Wound Assessment was not completed until several days later at which time, there were 2 new areas of altered skin integrity.

During a seventeen (17) day period, no Skin or Wound Assessments were completed on resident #009 despite the presence of altered skin integrity.

6. i) A review of resident #008's health care record noted the ongoing presence of altered skin integrity.

A review of the resident's health care record indicated that during a fourteen (14) day period, a Wound Assessment was not completed.

Staff did not comply with the licensee's Wound Care Management procedure related to Skin Integrity and Wound Assessments for resident #004, resident #009 and resident #008.
[s. 8. (1) (a),s. 8. (1) (b)]

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

The licensee was required to ensure that in accordance with O. Reg 79/10, s. 48 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: Continence Care and Bowel Management.

Specifically, staff did not comply with the licensee's Medical Directives procedure which is part of the licensee's Continence Care and Bowel Management Program (RC-16-01-05).

The Resident Medical Directive for the management of constipation directed staff on the following interventions:
- 2 days of no Bowel Movement (BM) - administer 2 tablets of senokot orally
- 3 days of no BM - administer bisacodyl/dulcolax suppository rectally
- 4 days of no BM - administer fleet enema rectally
- 5 days of no BM - contact physician/nurse practitioner

Resident #007's had Medical Directives signed by the physician.

A review of the resident's eMAR indicated that on a specified date, the Medical Directive was implemented for 4 days of no BM.

There was no indication that the Medical Directive for constipation was followed on days 2 and 3 of no BM.

8. Resident #004 had Medical Directives that were signed by the physician.

A review of resident #004's eMAR indicated that during a specific month, the Medical Directive was implemented 3 times.

On a specified date, a notation in the Digital Prescriber's Orders and a progress note indicated that the Medical Directive was implemented for 5 days of no BM. There was no indication that the Medical Directive was followed on days 2, 3 and 4 of no BM, or that the physician was contacted on day 5 of no BM. According to the electronic Medication Administration Record (eMAR), the intervention was effective.

On a specified date, a notation in the Digital Prescriber's Orders and a progress note indicated that the Medical Directive was implemented for 3 days of no BM. There was no indication that the Medical Directive was followed on day 2 of no BM.

According to the 24 Hour Unit Report, on a specified date, the resident was on day 2 of no BM; on a specified date, they were on 4 days of no BM, and on specified dates, they were on 5 days of no BM. On a specified date, a notation in the Digital Prescriber's Orders and a progress note indicated that the Medical Directive was implemented for 5 days of no BM. There was no indication that the Medical Directive was followed on days 2, 3 and 4 of no BM, or that the physician was contacted on day 5 of no BM. According to the eMAR, the intervention was effective.

Staff did not comply with the licensee's Medical Directives procedure related to the management of constipation for resident #007 and resident #004.
[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:
1. The Post Fall Management procedure with regards to neurological checks;
2. The Wound Care Management procedure with regards to Initial and Weekly Skin Integrity and Wound Assessments;
3. The Medical Directives procedure with regards to the management of constipation
are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe positioning techniques when assisting resident #004.

Critical Incident Report (CIR) 2579-000030-19 was submitted to the Director to report an incident that resulted in a significant change in the resident's status.

According to the CIR, during the provision of care by PSW #112, the PSW turned to fill a water basin, and while resident #004 was unattended on the bed, the resident fell onto the floor. The resident sustained injuries and was sent to the hospital for further assessment.

According to the resident's health care record, a Post Fall Huddle was held after the fall, and the reason for the fall was stated as "Resident left unattended in bed during care. Only 1 staff performing care as opposed to 2 staff".

In an interview with RPN #113, they indicated that they responded to the resident's fall. The RPN stated that the resident was two person assistance for care, did not move on their own and was dependent on staff for repositioning.

In an interview with the DOC, they stated that after the incident, PSW #112 was interviewed and had reported that they had resident #004 resting on them while the resident was laying on their side in the bed. As per the DOC, the PSW did not move the resident before they stepped away, and when they did so, the resident fell onto the floor.

The plan of care directed that resident #004 required two staff at all times for the provision of care.

Safe positioning techniques were not used to assist resident #004 when care was provided by one staff member, and the resident was left unattended on the bed and fell to the floor.
[s. 36.]

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 safe techniques are used when assisting residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

On a specified date, there was an altercation between resident #001 and resident #002. CIR 2579-000031-19 was submitted to the Director.

At the time of the incident, resident #001 was ordered several medications on a regular basis, and the physician orders directed staff to give the resident a specific medication on an as needed basis for severe agitation or aggression and to administer a second type of as needed medication, if the first one was not effective.

In an interview with the DOC, it was indicated that resident #001 had a specific pattern of walking, and if they were in 1 hallway only, they were pacing, and this was a trigger for a responsive behaviour.

In interviews with staff, including PSWs, registered nursing staff and an activity worker, it was indicated that the resident's facial expression is an indicator of their mood. Specifically the staff members indicated that when the resident is escalating towards a responsive behaviour, their facial demeanor visibly changes. Several staff members indicated that the resident's responsive behaviours are more prevalent on the evening shift, and that noise is a trigger for a responsive episode.

The PSW staff members indicated that at the first sign that resident #001 was escalating towards a responsive behaviour, they are to inform the RPN or the RN so that a prn medication can be administered.

In an interview with the DOC, they indicated that video footage showed that prior to the incident, resident #001's wandering changed to pacing. According to the CIR, resident #001 was pacing for approximately 30 minutes before the incident with resident #002. According to the DOC, resident #001 was approached by two different staff members (PSW #114 and PSW #117) who did not recognize the change in their behaviour and need for an intervention. As per the DOC when the resident began pacing, the resident required a prn dose of a specified medication. The DOC stated that video footage showed that PSW #117 ignored the sign of resident #001's escalation and did not redirect the resident appropriately.

In an interview with RPN #106, they stated that when resident #001 is pacing, they receive a prn dose of a specified medication. The RPN stated that they were not told of resident #001's need for a prn medication until after the incident with resident #002. According to RPN #016, the administration of the first type of as needed medication was effective, and resident #001 did not require the administration of the second type.

In an interview with RN #104, they stated that they were not made aware of resident #001's escalating behaviour prior to the incident with resident #002. As per RN #104, a code was called, and they contacted the on call physician who authorized a transfer to hospital.

The written plan of care for resident #001 indicated that resident #001 wanders without a rational purpose, can be socially inappropriate, physically aggressive and resistive to care. The distinction between resident #001's wandering versus pacing, their facial expression and noise as potential behavioural triggers, their tendency to be more responsive in the evening and the expectation that PSWs inform the registered nursing

staff at the first sign of escalation were not stated in the written plan of care. The DOC indicated that following BSO meetings and Psychiatry Consults, any identified triggers and interventions would be added to the written plan of care by the registered nursing staff on the unit in order to to minimize the risk of altercations and potentially harmful interactions between residents.
[s. 54. (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 steps are taken to minimize the risk of altercations and potentially harmful interactions between resident #001 and other residents by identifying and implementing interventions, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was exhibiting altered skin integrity received immediate treatment and interventions to reduce or relieve pain.

On a specified date, an RPN wrote a progress note that indicated that resident #001 was exhibiting altered skin integrity to a specified body part, and that the resident responded yes to pain.

A review of the resident's eMAR and Medical Directives indicated that after the resident responded yes to pain, the resident was not provided with pain medication.

On a specified date, resident #001 was exhibiting altered skin integrity, responded yes to pain and was not provided with an intervention to reduce or relieve pain.
[s. 50. (2) (b) (ii)]

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.