Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
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Téléphone: (613) 569-5602
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 04, 2020	2020_770178_0009 (A1)	005558-20, 008564-20, 014112-20, 017086-20	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

Amended by SUSAN LUI (178) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

This licensee inspection report has been revised to reflect a change in the Compliance Due Date for Compliance Order #001 from November 16, 2020, to December 21, 2020. The Critical Incident System inspection, #2020_770178_0009 was completed on October 15, 2020.
A copy of the revised report is attached.

Issued on this 4 th day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
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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 04, 2020	2020_770178_0009 (A1)	005558-20, 008564-20, 014112-20, 017086-20	Critical Incident System

Licensee/Titulaire de permis

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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

Amended by SUSAN LUI (178) - (A1)

Amended 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): September 15, 16, 17, 18, 21, 22, 23, October 1, 13, 2020.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log #005558-20, CIS #2579-000015-20 and Log #008564-20, CIS #2579-000017-20 were related to falls prevention and management;

Log #014112-20, CIS #2579-000023-20 was related to an episode of low blood sugar;

and Log #017086-20, CIS #2579-000027-20 was related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), an Assistant Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and a resident.

During the course of the inspection, the inspectors observed resident care areas and care provided to residents, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication

During the course of the original inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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 "The Medication Pass" policy was complied with for two residents.

O. Reg. 79/10, s. 114(1) requires an interdisciplinary medication management system to provide safe medication management for residents and (2) requires that written policies and protocols are developed for the medication management system to ensure accurate administration of all drugs used in the home.

“The Medication Pass” policy required that when a resident refused their medication the staff document the refusal on the medication administration record (MAR) and in the resident’s progress notes.

For a period of approximately 18 months, an RPN documented a “2” on resident #001’s electronic medication administration record (eMAR) almost daily to indicate that resident #001 refused their medications. The RPN did not write any progress notes in 2020 regarding the resident’s refusal of medications and actions taken as a result.

For three months, seven additional registered staff members documented "2" on the eMAR indicating that resident #001 refused medications on 26 occasions but did not document details about the refusal of medications and actions taken in a progress note.

For three months, the RPN and six additional registered nursing staff members documented "2" on resident #003’s eMAR indicating that the resident refused their medications on 16 occasions but did not document details about the refusal of medications and actions taken in a progress note.

Sources:
The Medication Pass policy;
eMARs and progress notes for two residents;
interviews with the DOC and RPN. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that are not controlled substances were destroyed by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing.

An RPN repeatedly disposed of medications that residents refused, without a second staff member to witness the drug destruction. The RPN indicated they were aware that disposal of non controlled drugs was supposed to be witnessed by another staff member, and had no explanation as to why they did not do so.

Sources:
Interviews with the DOC and RPN. [s. 136. (3) (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 drugs that are not controlled substances are destroyed by a team acting together and composed of:
i. one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
ii. one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to comply with the Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective June 30, 2020, when they did not report a resident's severe hypoglycemia to the Director of Care (DOC) or Assistant Director of Care (ADOC) and did not keep a written record of reporting the severe hypoglycemia to the substitute decision maker, the DOC or ADOC, and the pharmacy service provider.

The RPN wrote a progress note that described the resident experiencing severe hypoglycemia. Immediate actions to assess and maintain the resident's health were documented, however, the RPN does not remember if they notified the DOC or ADOC, the substitute decision maker, or the pharmacy service provider. Both the DOC and ADOC said they were not notified of the above incident of severe hypoglycemia and there was no written record reviewed or produced indicating if the DOC or ADOC, the substitute decision maker, or the pharmacy service provider were notified of the resident's severe hypoglycemia.

Sources:
Progress notes and plan of care for a resident;
eMAR for a resident;
Interview with DOC, ADOC, RPN, and other staff. [s. 174.1 (3)]

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 Minister's Directive: Glucagon, Severe Hypoglycemia, and Unresponsive Hypoglycemia, effective June 30, 2020, is complied with, to be implemented voluntarily.

Issued on this 4 th day of November, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SUSAN LUI (178) - (A1)
Inspection No. / No de l'inspection :	2020_770178_0009 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005558-20, 008564-20, 014112-20, 017086-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 04, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Medex 1865 Baseline Road, OTTAWA, ON, K2C-3K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tina Nault

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre: 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of O. Reg. 79/10.

Specifically, the licensee must ensure registered staff are following the home's medication administration policy when residents refuse their medications, by doing the following:

-Retrain the nine identified registered staff members who failed to follow the licensee's medication administration policy when two residents refused their medications, and continue to work in the home.

This retraining will address the interventions and reporting required when a resident refuses their medication, and records of attendance will be maintained;

-Implement a method for monitoring that the identified staff are consistently following the medication administration policy when residents refuse medications. The method must include identification of the person(s) responsible for monitoring, the frequency of monitoring, how it will be documented, corrective action to be taken and the person(s) responsible for implementing corrective action if monitoring demonstrates the policy is not complied with. This monitoring is to continue until consistent compliance with the medication administration policy is demonstrated by the identified staff members when residents refuse their medications. Records of this monitoring and any corrective actions taken shall be maintained.

-Implement a method to identify residents who repeatedly refuse their medications, including how nursing management will be alerted, what measures should be taken to address repeated refusal of medications, who will be responsible for ensuring those measures are taken, and how they will be documented.

Grounds / Motifs :

1. The licensee has failed to ensure "The Medication Pass" policy was complied with for two residents.

O. Reg. 79/10, s. 114(1) requires an interdisciplinary medication management system to provide safe medication management for residents and (2) requires that

written policies and protocols are developed for the medication management system to ensure accurate administration of all drugs used in the home.

"The Medication Pass" policy required that when a resident refused their medication the staff document the refusal on the medication administration record (MAR) and in the resident's progress notes.

For a period of approximately 18 months, an RPN documented a "2" on resident #001's electronic medication administration record (eMAR) almost daily to indicate that resident #001 refused their medications. The RPN did not write any progress notes in 2020 regarding the resident's refusal of medications and actions taken as a result.

For three months, seven additional registered staff members documented "2" on the eMAR indicating that resident #001 refused medications on 26 occasions but did not document details about the refusal of medications and actions taken in a progress note.

For three months, the RPN and six additional registered nursing staff members documented "2" on resident #003's eMAR indicating that the resident refused their medications on 16 occasions but did not document details about the refusal of medications and actions taken in a progress note.

Sources:
The Medication Pass policy;
eMARs and progress notes for two residents;
interviews with the DOC and RPN.

An order was made by taking the following factors into account:

Severity: Staff failed to follow the home's medication pass policy by failing to document a progress note when residents refused medications, making it more difficult to recognize the frequency of refusals. One resident repeatedly refused medications for more than a year, and their disease conditions exacerbated, requiring hospitalization.

Scope: The scope of this non-compliance was a pattern because the home's

medication pass policy was not followed by multiple registered staff members when two residents refused medications.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with s. 8 (1) of O. Reg. 79/10 and one written notification (WN) and two voluntary plans of correction (VPCs) were issued to the home.
(178)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 21, 2020(A1)

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4 th day of November, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by SUSAN LUI (178) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Service Area Office / Bureau régional de services : Ottawa Service Area Office