Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 8, 2016	2016_293554_0017	012130-16, 014091-16, 019629-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

KELLY BURNS (554)

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): July 19-22, 2016

The following intakes were inspected upon: Intakes #012130-16, 014091-16, and 019629-16.

Summary of Intakes:
1) #012130-16 - Critical Incident Report - allegation of resident to resident sexual abuse, involving resident #007 and #008;
2) #014091-16 - Critical Incident Report - allegation of staff to resident abuse/neglect, the said allegation, alleges that an identified registered nursing staff was withholding resident medication;
3) #019629-16 - Critical Incident Report - specific to missing medications (narcotics).

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Care (Clinical Coordinator), Office Manager, Nursing Clerk, Staff Educator/Best Practice Coordinator, Dietary Manager, RAI-Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Medical Advisor-Attending Physician, Peterborough Police Services and Residents.

During the course of the inspection, the inspector, toured the home, reviewed clinical health records, reviewed shift to shift narcotic and controlled substances counts, reviewed home specific investigations relating to the said Critical Incidents, reviewed pharmacy visit reports, reviewed program evaluations, specifically Zero Tolerance of Abuse and or Neglect, and Medication Management, and reviewed home specific policies, specifically Medication Incidents, Narcotics and Controlled Drugs, Emergency Drug Box and Resident Abuse-Staff to Resident, Resident Abuse-By Persons Other Than Staff, and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

10 WN(s)
7 VPC(s)
2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 residents in accordance with the directions for use specified by the prescriber.

Related to Intake #014091-16, for Residents #003, 004 and 005:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, as specified under the Long Term Care Homes Act (LTCHA, 2007), on an identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect, related to medications being withheld, were reported to have occurred during the evening shift on identified date.

According to the Critical Incident Report, the following incidents were said to have occurred:
- Registered Practical Nurse (RPN) #054 reported, to the Director of Care, that during his/her shift on an identified date, he/she witnessed RPN #050 withhold one resident's controlled substance and one resident's medication; RPN #054 reported that he/she witnessed RPN #050 place the two medications into his/her (RPN #050's) pocket. Registered Practical Nurse #054 indicated he/she is not sure which resident did not receive the medication during this incident, as many medications were being administered to residents in front of the dining room at the time. During this same shift, RPN #054 reports that RPN #050, did not administer medications to resident #003, and that RPN #050 placed the medication into his/her (RPN #050's) pocket; did not administer a indicated medication to residents #004 and #005 at 1700 hours. RPN #054 reports witnessing RPN #050 throw resident #004 and #005's medication scheduled for 2100 hours into the garbage. RPN #054 further indicated witnessing RPN #050 combining medications ordered at 1700 hours with the medications ordered for 2100 hours.

During an interview, with the inspector, Registered Practical Nurse #054 confirmed what he/she had witnessed on the identified date and what had been reported in the Critical Incident Report by the Director of Care.

During this same interview, Registered Practical Nurse #054 further alleges that during the said date, he/she also witnessed the following:
- RPN #050 did not administer all the prescribed eye drops, inhalers and or nose sprays to the residents needing the said medications. RPN #054 could not identify which residents did not received the said eye drops, inhalers and or nose sprays; nor could RPN #054 identify if the medications not administered were routine versus as needed medications.
- At approximately time on the said date, he/she witnessed Registered Practical Nurse #050 substitute resident #006's prescribed controlled substance with another medication. RPN #054 indicated RPN #050 stated to him/her "that resident #006 did not need the controlled substance". RPN #054 indicated that the medication had been prescribed to be given routinely to resident #006. RPN #054 could not identify who the other resident was during this said incident.

Resident #003, 004, and 005 are cognitively impaired and could not respond to questions asked by the inspector.

Resident #006 could not recall if he did or did not receive medications as ordered during the evening of the said date.

According to the Administrator, Registered Practical Nurse #050 was relieved of her duties on an identified date, pending investigation.

The Administrator indicated, to the inspector, that the said allegations were determined to be "unfounded".

The Director of Care employed during the time of the said allegations was not available for an interview during this inspection. [s. 131. (2)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or a combination of drugs, including psychotropic drugs.

Related to Intake #014091-16, for Residents #003, 004, 005 and 006:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect, related to withholding of medications, were reported to have occurred during the evening shift approximately nine days earlier.

According to the Critical Incident Report, the following incidents were said to have occurred:
- Registered Practical Nurse (RPN) #054 reported, to the Director of Care, that during his/her shift on a said date, he/she witnessed RPN #050 withhold medications which were prescribed for residents #003, 004, 005 and #006. RPN #054 indicated witnessing

RPN #050 pocket identified resident's medications, throw other medications, belonging to said residents, into the garbage and witnessed RPN #050 combining 1700 hour medications with the 2100 hour medications.

During an interview, with the inspector, Registered Practical Nurse #054 confirmed what he/she had witnessed on the said date and what had been reported in the Critical Incident Report by the Director of Care.

During the same interview, Registered Practical Nurse #054 further indicated that during the said date, he/she also witnessed the following:
- RPN #050 did not administer all the prescribed eye drops, inhalers and or nose sprays to the residents needing the said medications.
- At an identified time, he/she witnessed Registered Practical Nurse #050 substitute resident #006's prescribed controlled substance with another medication. RPN #054 indicated RPN #050 stated to him/her "that resident #006 did not need the medication." RPN #054 indicated that the medication had been prescribed to be given routinely to resident #006. RPN #054 indicated he/she witnessed RPN #050 place the controlled substance into his/her (RPN #050) pocket.

The licensee's policy, Medication Incidents (#11-18), directs the following:
- All medication incidents will be reported.
- Upon discovering or becoming knowledgeable about a medication incident, registered staff will report the incident to the supervisor or Director of Care or designate.
- If a resident is involved with the medication incident, the resident will be assessed and the physician informed.
- A Medication Incident Report will be completed and all known facts related to the medication incident will be documented. The factual details of the medication incident are to be documented in the resident's clinical record. All documents are to be forwarded to the Director of Care or designate for further investigation.

Registered Practical Nurse #054 indicated to the inspector, he/she did not intervene during the said incidents, nor did he/she report RPN #050 not administering medications as prescribed, and or allegedly pocketing the said medications to either the supervisor on shift that evening or the attending physician. RPN #054 indicated he/she did not report, what he/she had allegedly witnessed, to the management of the home for approximately nine day, at which time, a written report was submitted to the Director of Care.

At the time of this inspection, the Director of Care was unavailable for interview. As per

the Administrator, the DOC was no longer employed by the long-term care home.

The Administrator indicated, to the inspector, it is his belief that no ill effect occurred to residents #003, 004, 005 and or 006 on the above indicated date.

Registered Practical Nurse #054 did not take appropriate actions when she witnessed the said medication incidents, involving residents, during the evening shift of the said date. [s. 134. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure there is a written plan of care for the resident that sets out, (a) the planned care for the resident; and (b) the goals the care is intended to achieve, specific to safe-guarding resident #007, from resident #008.

Related to Intake #012130-16, for Resident #007:

Resident #007 has a cognitive impairment. Resident #007 is dependent on staff for activities of daily living.

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, specific to an allegation of resident to resident sexual abuse, which was said to have occurred three days earlier.

The clinical health record, specifically progress notes were reviewed for the said date. The review provided details of two incidents which occurred on the said date, both incidents alleged sexual abuse of resident #007 by resident #008.

Upon further review of the progress notes, there were four other entries, documented by registered nursing staff, describing incidents, of a sexual nature, involving residents #007 and #008, and/or entries in which resident #007, his/her substitute decision maker and or others designated by the resident voice concerns as to resident #007's safety.

The written plan of care fails to provide the planned care for resident #007, and/or the goals the care is intended to achieve, specific to safe-guarding of resident #007, from resident #008.

The Acting Director of Care indicated the written plan of care for all residents should be reflective of the care required by each resident. [s. 6. (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 there is a process in place and monitored, ensuring there is a written plan of care for resident #007 that sets out, (a) the planned care for the resident; and (b) the goals the care is intended to achieve, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to the medication management system.

Under O. Reg. 79/10, s. 114 (2), The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Related to intake #019629-14:

The licensee's policy, Narcotics and Controlled Substances (#11-20) directs the following:

- Two registered nursing staff (one leaving and one coming on duty) must complete a narcotic count at the end/beginning of each shift.
- The nurse going off and the nurse coming on duty will count together all of the narcotics and other controlled drugs.

A second policy, Emergency Drug Box (#11-12) directs that:
- The narcotics in the Emergency Drug Box are to be counted at the beginning and end of each shift as per other narcotics.

The Director of Care submitted a Critical Incident Report (CIR) to the Director on a said date, specific to an incident involving missing/unaccounted controlled substances from the Emergency Drug Box. The missing medications were said to have been noted as missing the prior evening.

During the home's investigation of the missing medications, it was discovered by the Director of Care and the Clinical Coordinator, that the Emergency Drug Box, which had contained the missing narcotics (controlled substance), had not been properly counted for approximately five days prior to the said incident. As per the Clinical Coordinator, now Acting Director of Care, the Emergency Drug Box had been last counted by two registered nursing staff on an identified date.

The Acting Director of Care and the Administrator indicated that during the investigation by the home, it was concluded that registered nursing staff had not followed home specific policies and procedures, specific to shift to shift count of narcotics and or controlled substances. [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 there is a process in place and monitored, ensuring that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, specific to the medication management system, especially as such relates to narcotics and or controlled substances, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

Related to Intake #014091-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect, related to withholding medications, were reported to have occurred during the evening shift approximately two weeks earlier.

According to the Critical Incident Report, the following incidents were said to have occurred:
- Registered Practical Nurse (RPN) #054 reported, to the Director of Care, that during his/her shift on an identified date, he/she witnessed RPN #050 withhold one resident's controlled substance and one resident's medications; RPN #054 reported that he/she witnessed RPN #050 place the two medications into his/her (RPN #050's) pocket. Registered Practical Nurse #054 indicated he/she is not sure which resident did not receive the medication during this incident, as many medications were being administered to residents in front of the dining room at the time. During this same shift, RPN #054 reports that RPN #050, did not administer medication to resident #003, and that RPN #050 placed the mediation into his/her (RPN #050's) pocket; did not administer a said medication to residents #004 and #005 at 1700 hours, and was witnessed throwing the same residents medication for 2100 hours into the garbage; witnessed RPN #050 combining medications ordered at 1700 hours with the medications ordered for 2100 hours.

During an interview, with the inspector, Registered Practical Nurse #054 confirmed what he/she had witnessed on the said date and what had been reported in the Critical Incident Report by the Director of Care.

During the same interview, with the inspector, Registered Practical Nurse #054 further indicated that during the identified date, he/she also witnessed the following:
- RPN #050 did not administer all the prescribed eye drops, inhalers and or nose sprays to the residents needing the said medications.
- At an identified time, he/she witnessed Registered Practical Nurse #050 substitute resident #006's prescribed controlled substance with another medication, RPN #054 indicated witnessing RPN #050 place the said medications into his/her (RPN #050) pocket.

The licensee's policy, Resident Abuse-Staff to Resident (#OPER-02-02-04) directs the following:
- All staff who have reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by a licensee or staff has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director (ON).
- Immediately report (verbally) any suspected or witnessed abuse, incompetent care or treatment to the Administrator, Director of Care or their designate (e.g. supervisor).

Registered Practical Nurse(RPN) #054 indicated that he/she did not report the witnessed incidents on said date to his/her supervisor, nor did he/she contact the Administrator and or Director of Care. RPN #054 indicated he/she advised the Director of Care of the said incidents nine days later (approximate). Registered Practical Nurse #054 indicated he/she did not report the said incidents, which occurred on said date, to the Director.

Registered Practical Nurse #054 indicated that he/she "considered the incidents in which he/she witnessed RPN #050 withholding medications from residents as abusive and also neglect of care."

Registered Practical Nurse #054 indicated being aware of the home's policy, surrounding zero tolerance of abuse. [s. 20. (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 there is a process in place and monitored, ensuring the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #6: 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 licensee failed to ensure the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to residents.

Related to Intake #014091-16, for Residents #003, 004, 005 and 006:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date. The DOC indicated in the CIR that alleged incidents, in which Registered Practical Nurse #050 withheld medications from said residents occurred during the evening shift approximately two weeks earlier.

As per the CIR, Registered Practical Nurse (RPN) #054 witnessed Registered Practical Nurse #050 withholding medications from residents #003, 004, and 005 on the said date. RPN #054 reported he/she also witnessed RPN #050 withholding resident #006's medications on the same date.

Registered Practical Nurse #054 indicated he/she advised the Director of Care of the incidents nine days post incident. This date was confirmed by Registered Nurse #055 and the Clinical Coordinator, who were both present at the time of the said meeting.

The Administrator was unable to comment as to why the Director of Care did not immediately report the allegation of RPN #050 withholding residents medications to the Director if she was aware of the incident on an identified date.

The Director of Care, at the time of this incident was not available to be interviewed. [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 there is a process in place and monitored, ensuring that all persons who have reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director, specifically improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies had been developed and implemented to respond to residents demonstrating responsive behaviours, where possible.

Related to Intake #012130-16, related to Resident #008:

Resident #008 has a cognitive impairment. Resident #008 ambulates independently.

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, specific to an allegation of resident to resident sexual abuse, which was said to have occurred on three days earlier.

The clinical health record, was reviewed for resident #007 and resident #008, specifically progress notes for the period of approximately two weeks; progress notes provide details of four incidents in which resident #008 was said to be exhibiting specific responsive behaviours towards resident #007.

The written plan of care fails to provide any evidence that strategies had been developed and or implemented, for time's when resident #008 was exhibiting identified responsive behaviours directed towards resident #007.

The Acting Director of Care indicated all residents exhibiting responsive behaviours should have strategies developed to decrease or eliminate risks to the said resident, as well as other residents.

The Administrator indicated "no strategies had been developed for resident #008, as it was believed the incidents alleged by resident #007 were untruthful."

At the time of this inspection, resident #008 was no longer residing at this long-term care home. [s. 53. (4) (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 there is a process in place and monitored, ensuring that strategies have been developed and implemented to respond to residents demonstrating responsive behaviours, to be implemented voluntarily.

WN #8: 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 the resident #007's substitute decision maker (SDM) and any other person specified by the resident were immediately notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident that, resulted in a physical injury or pain to the resident or that caused distress to a resident that could potentially be detrimental to the resident's health or well-being.

Related to Intake #01213-16, for Resident #007:

The Director of Care submitted a Critical Incident Report (CIR) to the Director on an identified date, specific to an allegation of resident to resident sexual abuse, which was said to have occurred approximately two weeks earlier.

The Clinical Coordinator, now the Acting Director of Care (DOC), indicated that resident #007 lacks insight and has a substitute decision maker for care decisions.

The clinical health record, for resident #007 was reviewed, and a substitute decision maker is documented, with name and contact information.

The clinical health record, specifically progress notes dated for the identified date, documents a said incident of alleged sexual abuse, towards resident #007 by resident #008. Progress notes provide details of resident #007 voicing being upset during, and following the said incident; resident #007 continues to voice being upset later that day and documents provide evidence indicating resident #007 refused lunch as he/she didn't want to share a table with resident #008.

The clinical health record, specifically a progress note, for the said date, and written by a registered nurse indicates resident #007's substitute decision maker was not notified on the said date of the alleged sexual abuse incident.

There is no other documentation contained within the clinical health record indicating that the substitute decision maker for resident #007 was notified of the said incident on the date to which the incident was said to have occurred.

The Acting Director of Care indicated that registered nursing staff should have contacted the substitute decision maker for resident #007 on identified date, upon becoming aware of the said allegation of sexual abuse involving the resident. [s. 97. (1) (a)]

2. The licensee failed to ensure that the resident's substitute decision maker (SDM) and any other person specified by the resident was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of a resident.

Related to Intake #014091-16, for Residents #003, 004, 005 and 006:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect were reported to have occurred during the evening shift approximately two weeks earlier.

As per the CIR, Registered Practical Nurse (RPN) #054 witnessed Registered Practical

Nurse #050 withholding medications from residents #003, 004, and 005 on the said date. RPN #054 reported he/she also witnessed RPN #050 withholding resident #006's medications on the same date.

Registered Practical Nurse #054 indicated he/she advised the Director of Care of the abuse/neglect of care incidents approximately nine days post incident. Registered Practical Nurse #054 indicated he/she herself did not notify the SDM for any of the residents involved on the evening of said date.

The Critical Incident Report, written by the Director of Care, and dated on a said date (approximately two weeks post incident), indicates the families of residents involved have not been contacted at this point as the allegation is being investigated.

The Acting Director of Care and the Administrator could not provide any documentation to suggest the said resident's and or resident's substitute decision makers were notified of the abuse/neglect allegations. [s. 97. (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 there is a process in place and monitored, ensuring that a resident's substitute decision maker (SDM) and any other person specified by the resident is notified upon becoming aware of the alleged, suspected or witnessed incident of abuse or neglect of a resident, as it relates to the said legislation, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Related to Intake #014091-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date. The DOC indicated in the CIR that incidents of staff to resident abuse/neglect were reported to have occurred during the evening shift on a specific date.

Registered Practical Nurse (RPN) #054 confirmed witnessing Registered Practical Nurse #050 withholding medications from residents #003, 004, 005 and #006 during the said date. Registered Practical Nurse #054 further indicated he/she witnessed RPN #050 pocketing resident's medications on the same date.

Registered Practical Nurse #054 indicated he/she advised the Director of Care of the abuse/neglect of care incidents approximately nine days later. This date was confirmed by Registered Nurse #055 and the Clinical Coordinator, who were both present at the time of the said meeting.

Registered Practical Nurse #054 indicated he/she did not notify the police on the date of the incidents.

The Administrator and the Acting Director of Care could not provide documentation to suggest that the police were notified of the incidents which were said to have occurred on the identified date, despite the former Director of Care being aware of such on a said date.

As per Police, the incidents said to have occurred on the identified date, were not reported to the Peterborough Police department.

The Acting Director of Care reported the said incident to the police during this inspection. [s. 98.]

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 there is a process in place and monitored, ensuring the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the report to the Director included the following description of the individuals involved with the incident, specifically did not include, (i) the names of all residents involved in the incident.

Related to Intake #014091-16:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on an identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect were reported to have occurred during the evening shift on a specific date (approximately two weeks earlier).

The Administrator provided the inspector with a copy of the home's investigational notes and witness statements, specific to the incidents which were said to occurred.

According to the investigational notes, and while interviewing registered nursing staff, the Clinical Coordinator (currently Acting Director of Care) and the Administrator, it was determined that not all residents involved with the said incidents were identified in the Critical Incident Report, submitted by the Director of Care.

Resident #006 and #009, who were identified in the home's investigational notes, were not indicated within Critical Incident Report. [s. 104. (1) 2.]

Issued on this 9th day of September, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KELLY BURNS (554)
Inspection No. / No de l'inspection :	2016_293554_0017
Log No. / Registre no:	012130-16, 014091-16, 019629-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Sep 8, 2016
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE PETERBOROUGH 80 ALEXANDER AVENUE, PETERBOROUGH, ON, K9J-6B4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Thurlow

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 Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The Licensee shall:
a) Develop and implement an effective monitoring system to monitor all parts of the medication administration, to ensure that all medications prescribed are administered to residents in accordance with the directions for use, specified by the prescriber; and that such is done in partnership with the home's Pharmacist.
b) Immediately upon being served with this compliance order and for fifteen (15) consecutive days after that date, conduct a daily audit of the electronic medication records (eMAR) for ten (10) percent of all residents for whom controlled drugs are prescribed to assess accuracy and completeness of information; ensure that the eMAR audit process includes a visual verification of all the key elements of the medication administration process, including but not limited to, ensuring that the right resident is receiving the right medication, at the right dosage, using the right route and administered at the specified time.
c) Take effective and appropriate action when registered nursing staff are not administering medication in keeping with legislative requirements, established practice standards, policies and procedures.

The licensee shall provide the written plan on or before September 16, 2016. The plan must be submitted in writing and forwarded to the attention of: Kelly Burns, LTC Homes Inspector (Nursing), via fax, at (613) 569-9670.

Grounds / Motifs :

1. The licensee failed to ensure that drugs are administered to residents in

accordance with the directions for use specified by the prescriber.

Related to Intake #014091-16, for Residents #003, 004 and 005:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director, as specified under the Long Term Care Homes Act (LTCHA, 2007), on an identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect, related to medications being withheld, were reported to have occurred during the evening shift on identified date.

According to the Critical Incident Report, the following incidents were said to have occurred:
- Registered Practical Nurse (RPN) #054 reported, to the Director of Care, that during his/her shift on an identified date, he/she witnessed RPN #050 withhold one resident's controlled substance and one resident's medication; RPN #054 reported that he/she witnessed RPN #050 place the two medications into his/her (RPN #050's) pocket. Registered Practical Nurse #054 indicated he/she is not sure which resident did not receive the medication during this incident, as many medications were being administered to residents in front of the dining room at the time. During this same shift, RPN #054 reports that RPN #050, did not administer medications to resident #003, and that RPN #050 placed the medication into his/her (RPN #050's) pocket; did not administer a indicated medication to residents #004 and #005 at 1700 hours. RPN #054 reports witnessing RPN #050 throw resident #004 and #005's medication scheduled for 2100 hours into the garbage. RPN #054 further indicated witnessing RPN #050 combining medications ordered at 1700 hours with the medications ordered for 2100 hours.

During an interview, with the inspector, Registered Practical Nurse #054 confirmed what he/she had witnessed on the identified date and what had been reported in the Critical Incident Report by the Director of Care.

During this same interview, Registered Practical Nurse #054 further alleges that during the said date, he/she also witnessed the following:
- RPN #050 did not administer all the prescribed eye drops, inhalers and or nose sprays to the residents needing the said medications. RPN #054 could not identify which residents did not received the said eye drops, inhalers and or nose sprays; nor could RPN #054 identify if the medications not administered were routine versus as needed medications.

- At approximately time on the said date, he/she witnessed Registered Practical Nurse #050 substitute resident #006's prescribed controlled substance with another medication. RPN #054 indicated RPN #050 stated to him/her "that resident #006 did not need the controlled substance". RPN #054 indicated that the medication had been prescribed to be given routinely to resident #006. RPN #054 could not identify who the other resident was during this said incident.

Resident #003, 004, and 005 are cognitively impaired and could not respond to questions asked by the inspector.

Resident #006 could not recall if he did or did not receive medications as ordered during the evening of said date.

According to the Administrator, Registered Practical Nurse #050 was relieved of her duties on a specific date, pending investigation.

The Administrator indicated, to the inspector, that the said allegations were determined to be "unfounded".

The Director of Care employed during the time of the said allegations was not available for an interview during this inspection.

The Licensee has been issued a previous non-compliance under O. Reg. 79/10, s. 131, during inspection #2013_196157_0018. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The License shall:
- Ensure that all registered nursing staff, including nursing management are provided with re-instruction, specific to the management and reporting of drug errors or incidents; taking appropriate actions in response to any drug incident; and the importance of adherence to drug administration and safe medication management policies, this re-instruction shall have a heightened emphasis of incidents involving controlled substances.
- Ensure that all registered nursing staff, including nursing management review home specific policies which relate to medication management and administration, specifically Medication Incidents (#11-18), Narcotics and Controlled Substances (#11-20), and the Emergency Drug Box (#11-12).

Grounds / Motifs :

1. The licensee failed to ensure that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or a combination of drugs, including psychotropic drugs.

Related to Intake #014091-16, for Residents #003, 004, 005 and 006:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on identified date. The DOC indicated in the CIR that incidents of alleged staff to resident abuse/neglect, related to withholding of medications, were reported to have occurred during the evening shift approximately nine days earlier.

According to the Critical Incident Report, the following incidents were said to have occurred:
- Registered Practical Nurse (RPN) #054 reported, to the Director of Care, that during his/her shift on a said date, he/she witnessed RPN #050 withhold medications which were perscribed for residents #003, 004, 005 and #006. RPN #054 indicated witnessing RPN #050 pocket identified resident's medications, throw other medications, belonging to said residents, into the garbage and witnessed RPN #050 combining 1700 hour medications with the 2100 hour medications.

During an interview, with the inspector, Registered Practical Nurse #054 confirmed what he/she had witnessed on the said date and what had been reported in the Critical Incident Report by the Director of Care.

During the same interview, Registered Practical Nurse #054 further indicated that during the said date, he/she also witnessed the following:
- RPN #050 did not administer all the prescribed eye drops, inhalers and or nose sprays to the residents needing the said medications.
- At an identified time, he/she witnessed Registered Practical Nurse #050 substitute resident #006's prescribed controlled substance with another medication. RPN #054 indicated RPN #050 stated to him/her "that resident #006 did not need the medication." RPN #054 indicated that the medication had been prescribed to be given routinely to resident #006. RPN #054 indicated he/she witnessed RPN #050 place the controlled substance into his/her (RPN #050) pocket.

The licensee's policy, Medication Incidents (#11-18), directs the following:
- All medication incidents will be reported.
- Upon discovering or becoming knowledgeable about a medication incident, registered staff will report the incident to the supervisor or Director of Care or designate.
- If a resident is involved with the medication incident, the resident will be assessed and the physician informed.

- A Medication Incident Report will be completed and all known facts related to the medication incident will be documented. The factual details of the medication incident are to be documented in the resident's clinical record. All documents are to be forwarded to the Director of Care or designate for further investigation.

Registered Practical Nurse #054 indicated to the inspector, he/she did not intervene during the said incidents, nor did he/she report RPN #050 not administering medications as prescribed, and or allegedly pocketing the said medications to either the supervisor on shift that evening or the attending physician. RPN #054 indicated he/she did not report, what he/she had allegedly witnessed, to the management of the home for approximately nine day, at which time, a written report was submitted to the Director of Care.

At the time of this inspection, the Director of Care was unavailable for interview. As per the Administrator, the DOC was no longer employed by the long-term care home.

The Administrator indicated, to the inspector, it is his belief that no ill effect occurred to residents #003, 004, 005 and or 006 on the above indicated date.

Registered Practical Nurse #054 did not take appropriate actions when she witnessed the said medication incidents, involving residents, during the evening shift of the said date. (554)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kelly Burns

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