Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 31, 2019	2019_668543_0003	029002-17, 009130-18, 013379-18, 024052-18	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare York
333 York Street SUDBURY ON P3E 5J3

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

TIFFANY BOUCHER (543), SYLVIE BYRNES (627)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 14-18 and 21-25, 2019.

A Critical Incident Inspection #2018_668543_0001 and a Follow-up Inspection #2018_668543_0002 were conducted concurrent with this inspection.

The following intakes were inspected during this inspection:

One intake, related to a complaint that was submitted to the Director regarding staffing levels,

One intake, related to a complaint that was submitted to the Director regarding care concerns,

One intake, related to a complaint that was submitted to the Director regarding care concerns and medication administration, and

One intake, related to a complaint that was submitted to the Director regarding care concerns, medication administration and Infection Prevention and Control practices.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Manager, Food Service Supervisors, family members and residents.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, internal investigation documents and policies and procedures.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Personal Support Services
Skin and Wound Care

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

2 WN(s)
2 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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 the resident as specified in the plan.

A complaint was submitted to the Director on a day in 2018, related to care concerns for resident #005, specific to meal service, falls and skin and wound care.

Inspector #543 reviewed resident #005’s care plan related to falls. The care plan identified that the resident was required to have specific interventions implemented, related to the prevention of falls.

The Inspector observed resident #005 on two separate occasions, and observed that the resident did not have the interventions applied.

Inspector #543 interviewed PSW #112, who indicated that the resident did require specific interventions, related to the prevention of falls.

Inspector #543 interviewed RPN #114, who verified that the resident’s care plan indicated that the resident was required to have the specific interventions applied at all times.

The Inspector interviewed RN #131, who verified that resident #005’s care plan identified that the resident was required to have the specific interventions applied at all times.

The Inspector interviewed the DOC regarding care plans, who indicated that it was the expectation that all residents’ have their care provided as specified in their care plan.

2. A critical incident (CI) report was submitted to the Director on a day in 2018. According

to the report, resident #007 was found in an altered state of health and specific interventions were performed for the resident.

Inspector #543 reviewed resident #007's progress notes from a day in 2018, and identified that the RPN was unable to locate forms that directed the care for this resident in the resident's medical record, therefore specific interventions were initiated for the resident.

The Inspector reviewed the home's internal investigation documents. Within those documents Inspector #543 reviewed the form that directed the care for resident #007.

Inspector #543 interviewed ADOC #127, who indicated that the specific form was part of the resident's plan of care. The ADOC verified that the resident's care was not provided as specified in their plan of care.

The Inspector interviewed the DOC, who verified that staff were unable to locate the specific form, and that that specific form was part of the resident's plan of care and that care was not provided as specified in the 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 the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

A complaint was submitted to the Director on a day in 2018, regarding resident #004 receiving the wrong medication.

Inspector #543 interviewed resident #004's family member, who indicated that their main concern was that the resident was administered a medication that was not prescribed for the resident.

The Inspector reviewed the home's "The Medication Pass" policy (3-6) which indicated that the right resident receives, the right medication of the right dose, at the right time, by the right route for the right reason and completed by the right documentation.

Inspector #543 reviewed the home's Medication Incident Notification form, that identified that resident #004 had been administered a medication that was prescribed for a different resident. The form identified that resident #004 identified the medication error.

The Inspector reviewed the home's medication incident audit form from a specific month in 2018, which identified that resident #004 was administered another resident's medication.

The Inspector interviewed ADOC #109, who verified that resident #004 received the wrong medication on a day in 2018.

The Inspector interviewed the DOC, who verified that the wrong medication was

administered to resident #004. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #002 submitted a complaint to the Director alleging that medication administration times for residents' medications were not followed, which the resident felt, may have had a negative effect on their health.

A) Inspector #627 reviewed resident #002's medical orders which identified a Physician's order, for a specific medication to be administered twice daily.

Inspector #627 reviewed resident #002's medication administration records for three consecutive months, and identified that for one specific month, the resident received 182 doses of the medication, of which nine doses, or five per cent were administered more than an hour before or after the scheduled administration time.

B) Inspector #627 reviewed resident #021's Physician's orders and identified an order for a specific medication to be administered twice daily.

Inspector #627 reviewed resident #021's medication administration record and identified for three consecutive months, resident #021 received 182 doses of the medication, of which 14 doses, or 8 per cent of the time, the medication was administered more than an hour before or after the prescribed administration time.

C) Inspector #627 reviewed resident #008's Physician's order and identified an order for a specific mediation to be administered four times a day.

Inspector #627 reviewed resident #008's medication administration record for three consecutive months, which indicated that resident #008 received 364 doses of the medication, of which 53 doses, or 15 per cent, were administered more than an hour before or after the scheduled time.

Inspector #627 interviewed the Pharmacist who stated that allotted time frame to administer a medication to a resident was one hour before or after the scheduled time.

Inspector #627 interviewed RPN #125 who stated that the home followed the College of Nurses of Ontario's (CNO) standards for medication administration, which specified that

a scheduled medication was to be administered within one hour before or after the scheduled medication time. They further stated that at times, when they were short staffed and had to administer medications to the floor, it was difficult not to be late with medications. RPN #125 stated that they reached out to their coworkers for assistance during those times; however, there was not always someone available to assist.

Inspector #627 interviewed the DOC, who stated that the home followed the CNO's recommendations for medication administration times, and that all scheduled medications were to be administered within an hour before or after the scheduled time. The DOC acknowledged that the aforementioned residents had not received their medication at the right time for the medications scheduled times. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 4th day of February, 2019

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

Original report signed by the inspector.