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

Division des foyers de soins de longue durée
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
Jul 24, 2017	2017_523461_0013	030014-16, 030812-16, 032159-16, 032728-16, 033756-16, 007457-17, 013020-17, 014024-17	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 PORT HOPE
360 Croft Street PORT HOPE ON L1A 4K8

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

CRISTINA MONTOYA (461), CAROLINE TOMPKINS (166)

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 18, 19, 20, 21, 2017

The following Critical Incident Logs were inspected:
013020-17 - Critical Incident related to a fall
014024-17 - Critical Incident related to a fall
030812-16 - Critical Incident related to transfer to hospital resulting in a significant change in condition
015462-17 - Critical Incident related to a fall
007457-17 - Critical Incident related to medication reported missing
032728-16 - Critical Incident related to a fall
030014-16 - Critical Incident related to alleged staff to resident abuse
032159-16 - Critical Incident related to alleged resident to resident abuse
033756-16 - Critical Incident related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Care (A-DOC), Acting Assistant Director of Care (A-ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Program Manager, RAI Coordinator, residents and family members.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **0 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Related to Log 030014-16

The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A Critical Incident Report (CIR) was submitted to the Director, related to allegations of staff to resident rough handling. The CIR indicated that resident #005 reported to PSW #114 to be experiencing pain and attributed the pain to how PSW #115 transferred and/or repositioned the resident.

The Acting Director of Care (A-DOC) and Acting Assistant Director of Care (A-ADOC), indicated the Home's investigation concluded that PSW #115's care was rough during transfer of resident #005.

During an interview with the Administrator, the A-DOC, the A-ADOC, and review of the Critical Incident reporting system indicated that the Director was not informed of the results of the Home's internal investigation of the alleged improper care to resident #005.

Licensee failed to report the results of the alleged abuse or neglect investigation to the Director. [s. 23. (2)]

WN #2: 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:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. Related to Log 030014-16

The licensee has failed to ensure that the report to the Director included the following analysis and follow-up actions: i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence.

A Critical Incident Report (CIR) was submitted to the Director, related to allegations of staff to resident rough handling. The CIR indicated that resident #005 reported to PSW #114 to be experiencing pain and attributed the pain to how PSW #115 transferred and/or repositioned the resident.

The Acting Director of Care (A-DOC) and Acting Assistant Director of Care (A-ADOC), indicated the Home's investigation concluded that PSW #115's care was rough during transfer of resident #005.

During an interview with the Administrator, the A-DOC, the A-ADOC, and review of the Critical Incident reporting system indicated that the Director was not informed of the immediate actions and long term actions planned to prevent recurrence of improper care during transferring for resident #005.

Licensee failed to report to the Director the immediate actions and long-term actions planned to the correct the situation and prevent recurrence of improper care to resident #005 related to transferring and bed mobility. [s. 104. (1) 4.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. Related to Log 007457-17

The licensee has failed to ensure the Director has been informed no later than one business day after the occurrence of the incident of: A missing or unaccounted for controlled substance.

A Critical Incident Report (CIR) was submitted to the Director, reporting an incident of a controlled substance missing/unaccounted.

The CIR documentation and review of the Licensee's investigation indicated that controlled substances were not located on resident #003's person.

Review of medication incidents from specified dates of current year and review of minutes of the Professional Advisory Committee (PAC) meetings that assesses and evaluate incidents of medication errors among other items, indicated medication incidents for the first quarter of 2017 were reviewed. During that time period there were 15 reported medication incidents, non causing serious harm to residents.

Review of the incidents indicated of the 15 reported incidents, there were six incidents of missing controlled substances, five related to resident #003's missing on specified dates.

Interview with the Administrator, the Acting Director of Care and review of the Critical Incident reporting system indicated the Director had not been informed of three incidents of missing or unaccounted for controlled substance which occurred on identified dates.

Two incidents of missing or unaccounted for controlled substance that occurred on specified dates were reported to the Director later than one business day after the occurrence of the incident. [s. 107. (3)]

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Issued on this 24th day of July, 2017

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

Original report signed by the inspector.