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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 17, 2019	2019_664602_0026	008192-18, 028018-18, 008431-19	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 Port Hope
360 Croft Street PORT HOPE ON L1A 4K8

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

WENDY BROWN (602), SUSAN DONNAN (531)

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): May 21 - 24, May 27 - 31 and June 3 - 7, 2019

Log # 028018-18 - regarding improper care specific to falls prevention and monitoring.
Log # 008431-18 - regarding medications.
Log # 008192-18 - regarding sufficient staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and family.

In addition, observations of resident care service delivery, and reviews of electronic health care records, meeting minutes, staffing records, laboratory results & tracking documents and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #010 as specified in the plan on three specified dates.

According to resident #010's MDS assessment they were at risk for falls. The resident's care plan indicated resident #010 is to self-propel in their wheelchair when not using foot rests versus being pushed from one location to another. Interventions specified that the resident was "able to self-propel their wheelchair independently, however, they required "extensive assistance from one staff member to get to specific locations".

On a specified date at a specified time a Personal Support Worker (PSW) was returning resident #010 to their unit when the staff stopped "propelling the resident forward"; the resident then fell to the floor striking their head. The post fall assessment/root cause analysis indicated resident #010 suffered an injury with causative factors leading to the fall noted as a "sudden stop". Follow up falls committee progress notes recommended that "staff [were] to be reminded that resident [#010] self propels and for staff not to push resident" while they are in their wheelchair.

One month later, resident #010 was being pushed in their wheelchair when the resident dropped their "feet down [resulting in their falling] …forward and [hitting their] head on the floor". The post fall assessment/root cause analysis notes indicated the resident received injury requiring transfer to hospital. The resident returned to the home later that day. Post fall committee recommendations indicated that when staff are pushing resident #010, footrests are to be on at all times.

Less than one month later, a third incident occurred when a PSW staff was "moving resident #010 in their wheelchair ...when [they] fell forward onto the floor". The post fall assessment/root cause analysis indicated the resident was injured. The head injury protocol was followed and it was decided to transfer the resident to hospital for assessment. Staff reported, in subsequent follow up, that they had placed resident #010's feet on the pedals initially, but that the resident must have removed them and dropped them to the floor causing them to tumble forward during transfer. A note was placed on the back of the resident's wheelchair to alert all staff to place resident's feet on foot pedals before wheeling. Falls committee recommendations were as follows: "ensure good communication passed on between shifts to prevent future falls regarding residents foot propelling and staff pushing them to ensure feet on foot rests when being assisted by staff".

Progress notes indicated that a new wheelchair was purchased a specified period of time later and there were no further similar incidents.

The licensee failed to ensure direction specific in the plan of care regarding the assistance required when resident #010 was moving from one location to another was provided. [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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a Registered Nurse (RN) is on duty and present at all times.

Extendicare Port Hope is a128 bed Long-Term Care Home.

A review of the RN staffing schedule for 2018 indicated that on April 15, 2018 there was no RN in the building for the evening shift.

Ontario Regulation 79/10 section 45.(2) indicates that "emergency" means an unforeseen situation of a serious nature that prevents a RN from getting to the long-term care home. The shift was reviewed and discussed with the Director of Care #101 (DOC) who confirmed that an emergency did not exist where the exception as per Ontario Regulation 45.(2).ii would apply. DOC #101 reported that an additional Registered Practical Nurse (RPN) was scheduled on April 15, 2018 by previous DOC #108, related to exceptional weather conditions.

Every licensee of a long-term care home shall ensure that at least one RN, who is both an employee of the licensee and a member of the regular nursing staff of the home, is on duty and present in the home at all times [s. 8. (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 at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 114 (1), the licensee was required to ensure that a medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents was in place. Specifically, staff did not comply with the licensee's "Anticoagulant Therapy" Policy RC-16-01-17 (revised February 2017) which is part of the licensee's Resident Care / Medication Management System.

Resident # 010 was admitted to the Long Term Care (LTC) home on a specified date, with multiple diagnoses including one that required an anticoagulant medication.

On a specified date, resident #010 was noted to be bleeding from their mouth. The physician was alerted and the family was contacted. A review of the laboratory testing results revealed that the laboratory results for a specified period had not been received; thus, a test result was missed and the medication dosage was not adjusted. Investigation by the licensee into the missing test result(s) found that the laboratory facsimile did not go through and that there was no follow up by the laboratory or the home to (re)send, obtain and/or review, the result(s) until symptomatic bleeding was noted. The physician spoke with the family and reviewed concerns about laboratory notification and laboratory test monitoring. DOC #101 indicated that a "new protocol [would be] instituted to check for test results … to make sure nothing missed".

Resident #010 received medication in the home in an effort to return blood coagulation to

a therapeutic range, however, the decision was made to transfer the resident to hospital for assessment. Resident #010 was returned to the home that day with blood testing within a therapeutic range.

DOC #101 explained that post incident investigation into laboratory services revealed a number of issues, and resulted in a change in providers. Staff have been directed to consistently use the Anticoagulant/Tracking Record associated with Anticoagulant Therapy Policy RC-16-01-17. Procedure item 1. indicates "all residents receiving anticoagulant therapy must have a Physician/Nurse Practitioner order which clearly identifies the dosage and frequency of medication and the frequency of" blood testing. Item 2. indicates the "nurse will document the administration of anticoagulants and record [blood test] results". Despite efforts to improve monitoring and tracking of test results as outlined in procedure items 1. and 2., a review of the 2019 Anticoagulant/Tracking Records for the only two residents currently receiving a specified anticoagulant medication in the home, residents #018 and #019, showed resident #019 was missing laboratory test results for three specified dates in 2019 and resident #018 did not have results for on specified date in 2019. In addition, interviews with registered staff #125, #126, and #127 indicated that there was currently no follow up system to ensure the home connected with the laboratory for missing blood work results.

The licensee failed to ensure that their medication management policy, the safe administration of "Anticoagulant Therapy" RC-16-01-17, was complied with. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any system, the licensee is required to ensure that the policy (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with, to be implemented voluntarily.

WN #4: 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 has failed to ensure drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

Inspector #531 reviewed resident #001's physician orders on a specified date which indicated that the resident had been prescribed a specified medication.

On a specified date, during an interview with the DOC and review of an incident report indicated that on a specified date, RN #128 had discovered that resident #001 had been administered twice the prescribed dose of the medication. The DOC indicated that RN #128 recognized the error, assessed resident #001, notified the physician, management and monitored the resident. The ADOC notified the SDM.

The DOC indicated that there were no untoward effects to resident #001.

The licensee failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 17th day of June, 2019

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

Original report signed by the inspector.