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

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 15, 2019	2018_643111_0026	031577-18	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 Haliburton
167 Park Street P.O. Box 780 HALIBURTON ON K0M 1S0

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

LYNDA BROWN (111)

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): December 10 and 11, 2018

A complaint inspection was completed related to multiple items.
A critical incident (CIR) was also inspected concurrently during this inspection related to falls for the same resident.

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

During the course of the inspection, the inspector reviewed the health record of a resident, reviewed maintenance logs, reviewed medication incident report, reviewed the home's complaints and reviewed the following policies: complaints and customer service, remedial(demand) maintenance program.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Medication
Minimizing of Restraining
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **5 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. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the restraint policy was complied with.

A complaint was received by the family of resident #001 indicating the resident was given a chemical restraint without the Substitute Decision Maker (SDM) consent.

Review of the health care record for resident #001 indicated under the physician orders, on a specified date, an order to administer a specified medication at a specified dose and time for a responsive behaviour.

Review of the licensee's Chemical Restraints (RC-16-01-30) policy that was updated February 2017 indicated:
-Complete a restraint assessment prior to the initiation of a chemical restraint.
-Obtain a signed restraint consent from the resident/SDM/POA prior to administration.
-Ensure the resident's POA/SDM understands the medication that has been ordered, reason for use and possible adverse side effects.
-Use the Responsive Behaviour Record to map a resident's behaviour while the chemical restraint is being used and review ongoing requirement for restraint use based on behaviours.

There was no documented evidence of a restraint assessment completed prior to the initiation of the chemical restraint or a signed restraint consent from the resident's SDM.

Review of the Responsive Behaviour Record indicated:
-On a specified date and time, the resident was demonstrating specified responsive behaviours and was administered the specified medication.
-On a specified date and time, the resident was demonstrating specified responsive behaviours. Identified interventions were implemented with no effect and the resident was then administered the specified medication.
-There was no indication of a responsive behaviour record for two other specified dates and times when the resident was administered the specified medication.

Review of the Medication Administration Record (MAR) for resident #001 for a specified month, indicated there was no indication on a specified date and time that the specified medication was signed as administered (as indicated in the progress notes). The resident was administered the specified medication on three other separate dates and times.

Review of the progress notes for resident #001 indicated:
-on a specified date, the resident was demonstrating specified responsive behaviours and specified complaints. The Physician and SDM were notified and agreed to transfer resident to hospital for an assessment. Later the same day, the resident returned from the hospital with a physician order to hold a specified medication and all medications that caused sedation. A short time later, the resident sustained a fall with no injuries. A message was left for the SDM regarding the fall and medication changes. Later the same day, the resident began demonstrating specified responsive behaviours and required increased assistance with transfers. The resident continued to demonstrate specified responsive behaviours and was at risk for falls. The physician was contacted, a new order was received for a chemical restraint medication at specific doses/times, for a specified responsive behaviour (despite previous order not to give any sedating medications) and was given the medication. The SDM was called again and a message left regarding new medication order.
-on the following day, the resident was found on the floor in room with no injuries, but complaining of pain to a specified area and having difficulty with voiding. The physician was notified of difficulty with voiding and new orders were received. The resident's transfer status was also changed due to decreased ability to self-transfer or with staff assistance. Later on the same day, the resident sustained another fall in their room while attempting to self-transfer. The resident's specified vital sign was elevated. Later the same day, the resident sustained another fall in their room with no injuries. The resident was then placed in front of the nursing desk for closer observation. Later that same day, the resident was given a specified medication for responsive behaviours.
-Two days later, at a specified time, the resident sustained a fall in a specified area and sustained an injury to a specified area. The resident's specified vital sign was elevated, injuries were noted to specified areas and the resident was transferred to hospital for assessment. Later the same day, the resident returned from hospital with no new orders. A short time later, the resident sustained another fall. The resident was transferred back to hospital. The resident returned from hospital later the same day and specified interventions were implemented.
-on a specified date and time, the resident was awake and demonstrating responsive behaviours. A specified medication and a pain medication was given with little effect. Later on, the resident was demonstrating responsive behaviours, the resident was placed at the nursing station for close monitoring, specified interventions were used with no effect and a specified medication was given. The family was notified of the resident's status and requested the resident be transferred to the hospital for assessment.
-The following day, the DOC indicated the resident remained at the hospital and family expressed concerns regarding the use of a chemical restraint without the SDM's consent.

The DOC confirmed that the chemical restraint policy was not followed.

During an interview with the acting DOC, the acting DOC confirmed that resident #001 was provided a specified medication (chemical restraint) without obtained consent from the SDM prior to administration, and had no restraint assessment completed, as per the licensee's chemical restraint policy.

The licensee failed to ensure their chemical restraint policy was complied with for resident #001.

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 licensee's chemical restraint policy is complied with, 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. (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 :

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

A complaint was received from the family of resident #001 regarding a medication incident.

Review of the physician orders for resident #001 indicated on a specified date, the physician ordered a pain medication at a specified dose, twice daily and to be increased to double the dose after two weeks, if pain was not improved.

Review of the medication incident report for resident #001 indicated on a specified date, RPN #100 discovered the resident was given the pain medication in error for a specified number of days.

During an interview with RPN #100, the RPN indicated they completed an assessment of the resident and then reported the medication incident to RN #104 and the family. The RPN confirmed they did not document the assessment of the resident or when the family was notified and just completed the medication incident report. The RPN indicated the RN was supposed to notify the physician.

Review of the home's investigation and the medication administration record (MAR) for the specified month for resident #001 indicated, three registered staff (RPN #101, #102 and #103) were involved in the medication incident.

Review of resident #001's progress notes indicated RN #104 documented awareness of the medication incident and a note was left for the physician. There was no documented evidence of an assessment of the resident.

The licensee has failed to ensure that a pain medication was administered to resident #001 in accordance with the directions for use, specified by the prescriber.

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.

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. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident was being reassessed and the plan of care is being revised because care set out in the plan had not been effective, that different approaches had been considered in the revision of the plan of care.

The licensee currently has an outstanding order for LTCHA, 2007, s.6(11)(b) with a compliance date of March 15, 2019, related to falls.

A critical incident report (CIR) was received by the Director on a specified date, for a fall that resulted in injury for which the resident was transferred to hospital, that resulted in a significant change in condition. The CIR indicated that on a specified date and time, resident #001 sustained a fall in a specified area. The resident was transferred to hospital and returned a short time later with injuries to specified area. The resident then sustained a second fall a short time later and was transferred back to hospital. The resident returned from hospital later the same day and was placed on one to one monitoring.

Review of the health care record for resident #001 indicated the resident had diagnoses that included weakness to specified areas. The progress notes for a two week period indicated the resident sustained a number of falls during that period, until the resident was admitted to hospital and placed on palliative care. During that time, the resident was placed on new medications (pain and chemical restraint), was involved in a medication incident and sustained specified injuries to specified areas. The resident's level of mobility/transfer status was also deteriorating. The resident's mobility aid was also malfunctioning during that time.

Review of the written plan of care in place for resident #001 prior to the falls indicated the resident was at high risk for falls. There were specified interventions indicated.

During an interview with PSW #106, the PSW indicated prior to resident #001 sustaining the falls, the resident was able to transfer independently and required minimal assistance with care. The PSW indicated the resident began to deteriorate, fell a number of times, despite using a specified intervention. The PSW indicated additional specified interventions were put in place, but could not recall when the interventions were put in place.

There was no indication that the plan of care was revised when the planned care was ineffective in preventing falls or reducing the severity of injury from the falls until after the resident sustained multiple falls. The resident's mobility aid was not reassessed until after the resident sustained an number of falls. After another fall, an additional fall protective device was put in place. A few days later, another fall protective device was put in place, but only for a specified area, despite most of the falls occurring in another specified area. A restraint was not considered despite request from family. The resident was also given specified medications that increased the resident's potential for falls and despite an order from a physician not to give any sedating medications, after the first couple of falls.

Interview with the acting DOC indicated they had only been in place for the last two weeks, as the previous DOC went on maternity leave. The acting DOC indicated they were unable to locate any post falls meeting minutes documented regarding resident #001, to indicate other interventions that were considered and confirmed the plan of care was not revised, despite the resident having multiple falls in a specified period.

The licensee failed to ensure that when resident #001 was being reassessed, that the plan of care was revised related to falls, when the care set out in the plan had not been

effective and that different approaches were considered in the revision of the plan of care. There was no indication the plan of care was revised when the planned care was ineffective in preventing falls or reducing the severity of injury from the falls for resident #001 until after the resident sustained multiple falls.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's plan of care was based on an interdisciplinary assessment of the resident's continence, including bowel elimination.

A complaint was received from the family of resident #001, indicating a concern related to the resident's elimination pattern.

Review of the current written care plan for resident #001, indicated the resident was able to transfer and toilet self independently. There was no other planned care for the resident related to the resident's elimination pattern.

Review of the point of care (POC) for resident #001, for a specified month, indicated the resident had an alteration in elimination.

Review of the medication administration record (MAR) for resident #001, for a specified month, indicated the resident received specified medications for alteration in elimination pattern.

During an interview with PSW #106, the PSW indicated, resident #001 usually transferred independently to toilet self and would report any bowel function. The PSW indicated the resident began to decline in level of mobility over a period of time and required staff assistance with transfers/toileting. The PSW indicated any bowel function for the resident was reported on the POC under elimination and the PSW would report to

registered staff, if the resident had not moved their bowels.

Review of the progress notes over a specified period, for resident #001 related to elimination indicated the resident had a new medication ordered for altered elimination patterns. The resident was also provided additional medications for altered elimination pattern on specified dates. On a specified date, the resident was complaining of pain and a change in condition to a specified area. The resident was assessed by the physician and nurse practitioner. The resident was transferred to hospital and diagnosed with a change in condition related to altered elimination.

Interview with the acting DOC, the acting DOC confirmed when the resident was sent to hospital on a specified date, the family and physician reported the resident had an alteration in elimination pattern. The acting DOC indicated they would have expected there to be a written care plan for resident #001 related to alteration in elimination pattern, since the resident was receiving medications daily for altered elimination.

The licensee had failed to ensure that resident #001's plan of care was based on an interdisciplinary assessment of the resident's altered elimination pattern.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

The licensee has failed to ensure that procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home, are kept in good repair.

A complaint was received by the SDM of resident #001 related to a lack of required

equipment in the resident's room.

Observation of resident #001's bathroom on a specified date and time, indicated there was appropriate equipment in place in the residents room.

During an interview by Inspector #111 with RN #104, the RN indicated resident #001 had a specified piece of equipment removed from room on a number of occasions, due to a responsive behaviour. The RN indicated the current equipment in place in the resident's room was relocated to a new area but was unable to recall when the equipment was put in place, but was put in place as result of the family's complaint. The RN indicated any maintenance concerns (i.e. equipment in disrepair) was to be placed in the maintenance log book and confirmed there were no requests made to have the specified piece of equipment repaired/replaced.

During an interview by Inspector #111 with PSW #106, the PSW confirmed resident #001 used to have a specified piece of equipment in the residents room but was removed on a number of occasions, due to the residents responsive behaviour. The PSW indicated the piece of equipment was recently replaced with new equipment but unaware of when this occurred. The PSW also confirmed that any maintenance concerns (i.e. equipment in disrepair) were to be placed in the maintenance log book.

During an interview by Inspector #111 with maintenance staff, the maintenance staff indicated the resident used to have a specified piece of equipment in their room but kept removing the equipment on a number of occasions, so the equipment was permanently removed for a specified period of time. The maintenance staff was unable to indicate when the piece of equipment was in disrepair, how often the equipment was repaired or when it was removed. The maintenance staff confirmed a new piece of equipment was installed after a complaint was received from family regarding the missing/dis-repaired equipment. The maintenance staff confirmed that staff were to indicate in the maintenance log when repairs were required and confirmed there was no indication that this occurred.

Review of the progress notes for resident #001 indicated on a specified date, RN #104 indicated the family expressed concerns regarding dis-repaired/missing equipment from the resident's room. The RN informed the family that the resident was using the specified piece of equipment inappropriately on multiple occasion and it was in disrepair. On a specified date, the DOC indicated a follow-up with the family complaint. The DOC informed the family that the equipment was removed as the resident was using the

equipment inappropriately. The DOC indicated a new piece of equipment would be put in place for the resident. There was no other documented evidence of the resident breaking the equipment. The notes did not indicate when or how often the original piece of equipment was broken, when it was replaced and only indicated when the new equipment was installed, after receiving a complaint from the family.

Interview with the acting DOC and Administrator indicated the expectation was that all staff were to document any maintenance requests in the maintenance log book and the maintenance staff is to sign off when the work has been completed. The acting DOC confirmed a complaint was received from the family regarding missing piece of required equipment and was documented in the resident progress notes.

The licensee has failed to ensure that procedures developed, were implemented, to ensure that all equipment in resident #001's room was kept in good repair.

Issued on this 18th day of January, 2019

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

Original report signed by the inspector.