Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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
Mar 4, 2020	2020_603194_0006	001211-20	Critical Incident System

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 Kawartha Lakes
125 Colborne Street East LINDSAY ON K9V 6J2

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

CHANTAL LAFRENIERE (194)

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): January 22, 23, 27, and February 20, 2020.

A Critical Incident related to staff to resident abuse was inspected.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Clinical Care Coordinator, (CCC), Physician, Police and Coroner.

The inspector reviewed the internal abuse investigation, staff abuse educational records, clinical health records of identified residents, narcotic records, relevant policies related to Abuse and Medication administration.

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

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **6 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 failed to ensure that the care set out in the plan related to a specified therapy was provided to the resident #001 as specified in the plan.

During review of a Critical Incident Report (CIR) submitted to the Director, for allegations of staff to resident abuse Inspector #194 reviewed resident #001's plan of care.

Review of the plan of care related to the specified therapy indicated that the therapy had been ordered for the resident through a medical directive. The order for the specified therapy indicated that if a resident was experiencing specific symptoms, the registered staff were to administer the therapy, as needed (PRN) with detailed perimeters for administration.

RN #106 documented that they administered the specified therapy to resident #001,outside the perimeters for administration.

During interview with Inspector #194, RN #106 confirmed they had administered the specified therapy for resident #001, outside the detailed perimeters for administration, as they wanted resident #001 to be comfortable. RN #106 indicated that they were unaware of the perimeters for the specified therapy, as outlined in the medical directive for resident #001.

The licensee failed to ensure that the care set out in the plan of care related to administration of the specified therapy was provided to resident #001 as specified, when RN #106 administered the specified therapy, outside the perimeters for administration. [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 by ensuring 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. 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 of this Regulation required the licensee of a long-term home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O.Reg. 79/10 s. 114.(2) the licensee was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate dispensing and administration of all drugs used in the home.

The licensee's "PRN Medication", Policy #RC-16-01-14 dated February 2017 indicated that the e-Mar was to be used to document when a PRN was given. The policy directed that progress notes were to be use to document the assessment prior to determining that a PRN medication was required as well as to document the effectiveness of the PRN given.

Licensee's "Medication Management" policy # RC16-01-07 dated December 2019 indicated that registered staff were not to prepare medications in advance (pre-pour), and that all medication administered were to be documented in the e-Mar.

A CIR was submitted to the Director indicating that PSW #104 and PSW #105 worked with RN #106 when comments made by the RN #106 regarding the death of the resident concerned them.

The clinical health records, Physician Orders/eMAR indicated the specific medications were ordered for resident #001 during the reviewed period.

During interview with Inspector #194, RN #106 explained that resident #001 was

palliative. RN #106 indicated that they administered all PRN medication available for resident #001 during the reviewed period to ensure that resident #001 was comfortable. RN #106 confirmed that documentation of assessments were brief and documentation of medication administration times were delayed. RN #106 confirmed during the interview that they had pre-poured medication. RN #106 reviewed the medication records and progress notes, for resident #001 clarifying the times of administration and assessments completed.

Review of the MARS and Point Click care medication reports for the reviewed period for resident #001 indicated that RN #106 was late in documenting for the administration of several doses of medication . RN #106 did not document in the eMar for the administration of one dose of medication for resident #001.

Review of the progress notes for resident #001 for the reviewed period, related to assessment for medication administration by RN #106 was completed. There were no assessments completed by RN #106 to support administrations of the medications to resident #001 during the reviewed period.

Inspector #194 expanded the scope of the inspection to include resident #003.

The clinical health record for resident #003 indicated that the physician had ordered, specific medication with detailed administration directions.

Review of resident #003's eMAR for a specific period, indicated that RN #106, did not document the administration, for one dose of the specified medication.

Resident #003's progress notes for the identified period were reviewed . There was no assessment documented by RN #106 for resident #003 prior to the administration of the specified medication.

Review of the licensee's internal investigation indicated that an RN #106 could not provide any explanation related to the discrepancy in the documentation of the medication administration or the lack of assessments prior to administration in the progress notes when interviewed by the management of the home.

The licensee failed to ensure that it’s Medication policies were complied when RN #106 pre-poured, specific medication, for resident #001. RN #106 failed to document immediately in the eMAR when medications were administered to resident #001 and

failed to ensure that an assessment of the resident's condition was documented in the progress notes prior to administering the medication. RN #106 failed to document in the eMAR resident #003's, medication administration on a specified date. RN #106 failed to ensure that an assessment of the resident #003's condition was documented in the progress notes prior to administering several doses of specified medication. [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 by ensuring 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 plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #3: 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 that it's Zero Tolerance of Resident Abuse and Neglect Program was complied with.

Review of the Zero Tolerance of Resident Abuse and Neglect: response and reporting, Policy # RC-02-01-02 dated June 2019, indicated that anyone who witnesses or suspect abuse of a resident must notify management immediately.

Review of the Zero Tolerance of Resident Abuse and Neglect: Investigation and Consequences, Policy # RC-02-01-03 dated June 2019, indicated that Administrator or designate will promptly initiated an investigation into abuse, ensuring that reporting requirement to regulatory bodies have been completed.

A CIR was submitted to the Director indicating that PSW #104 and PSW #105 worked with RN #106 when comments made by the RN #106 regarding the death of the resident concerned them.

During interview with Inspector #194, RN #110 indicated that PSW staff had reported a suspicion of abuse involving resident #001 on an identified date. RN #110 indicated that they did not report to the MLTC, or inform the management staff at the home. RN #110 indicated that immediate investigation into the allegations were not initiated as directed by the licensee's policy.

During separate telephone interviews with Inspector #194, PSW #104 and PSW #105 indicated suspicion of resident abuse involving resident #001. PSW #104 and PSW #105 indicated that they did not immediately report the suspicion of abuse as they were not able to verify if the comments made by the RN #106 had actually taken place.

The licensee failed to ensure that it's abuse policy was complied, when PSW #104 and PSW #105 did not immediately report the suspicion of staff to resident abuse involving RN #106 to immediate supervisor. The abuse policy was not complied when PSW #104 and PSW #105 reported allegations of abuse to RN #110 and the Director was not immediately informed, management at the home was not informed and an immediate investigation into the allegations were not initiated. [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 by ensuring 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, to be implemented voluntarily.

WN #4: 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. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an immediate investigation was initiated when an allegation of staff to resident abuse was reported by PSW #104 and PSW #105 to RN #110.

A CIR was submitted to the Director indicating that PSW #104 and PSW #105 worked with RN #106 when comments made by the RN #106 regarding the death of the resident concerned them.

During interview with Inspector #194, RN #110 indicated that they were RN in charge in the building with PSW #104 and PSW #105 on the identified date. RN #110 indicated that PSW #104 and PSW #105 reported the suspicions of abuse involving resident #001, when they had been working with RN #106. RN #110 indicated during interview that they directed the PSWs to report to the management of the home immediately. RN #110 indicated that the incident described by the PSWs was an allegation of abuse. RN #110 indicated that they did not initiate an immediate investigation into the reported abuse.

The licensee failed to ensure that an immediate investigation was initiated for a reported allegation of abuse involving resident #001 received on an identified date, by RN #110. [s. 23. (1) (a)]

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 by ensuring that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #5: 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 that the person who had reasonable grounds to suspect that abuse may have occurred, immediately report the suspicion and the information upon which it was based to the Director.

A CIR was submitted to the Director indicating that PSW #104 and PSW #105 worked with RN #106 when comments made by the RN #106 regarding the death of the resident concerned them.

During interview with Inspector #194, RN #110 indicated that they were RN in charge in the building with PSW #104 and PSW #105 on the identified date. RN #110 indicated that PSW #104 and PSW #105 reported the suspicions of abuse involving resident #001, when they had been working with RN #106. RN #110 indicated during interview that the PSWs were directed to report to the management of the home immediately. RN #110 indicated that the incident described by the PSWs was an allegation abuse. RN #110 indicated that they did not immediately report to the Director or inform the management of the home.

During telephone interview with Inspector #194, PSW #104 indicated that they had never been in this situation before, and when RN #106 stated everything worked out in the end, they were less concerned. After days of discussing situation with their partner and reviewing the comments made, the decision to confided in RN #110 was made. PSW

#104 indicated that RN #110 directed them to report incident and to speak DOC and management. PSW #104 indicated that they came into the home a number of days later and informed DOC.

During telephone interview with Inspector #194, PSW #105 indicated that the comments made by RN #106 involving resident #001 “had not sat well with them”. PSW #105 expressed that they were hesitant to report the comments, because they were unable to verify if anything had occurred. PSW #105 indicated that discussions with PSW #104 over the comments had taken place and the decision was reached to confide in RN #110 to discuss their concerns. PSW #105 indicated that RN #110 directed them to report the allegations to the DOC and management of the home. PSW #105 indicated that they reported the allegations of abuse involving RN #106 to the DOC two days later.

The licensee failed to ensure that RN #110 who had reasonable grounds to suspect that abuse of resident #001 may have occurred, when PSW #104 and PSW #105 reported the allegations and did not immediately report the suspicion and the information upon which it was based to the Director. The Director was notified of the allegations of staff to resident abuse when the PSW’s came to the home to report the allegations to the DOC. [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 by ensuring that any person who has reasonable grounds to suspect that abuse may have occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: 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 the medication was administered to resident #001 in accordance with the directions for use specified by the prescriber.

A CIR was submitted to the Director for allegations of staff to resident abuse, involving resident #001. Inspector #194 reviewed resident #001's medication records for an identified period and noted two medication discrepancies. Review of resident #001's Individual Monitored Medication Records for resident #001 related to the administration of a specific medication was completed and identified that different dosages were ordered for routine and as needed doses.

On a specific date, RPN #111 documented and signed for a routine dose of the specified medication for resident #001.

During interview with Inspector #194, RPN #111 indicated that the documented "routine" dose was given as documented on the Individual Monitored Medication record. Inspector #194 clarified with RPN #111 that resident #001's prescribed routine dosage for specified medication was different from the as needed dosage. RPN #111 indicated that they could not recall and that the documentation in progress notes and on the Individual Monitored Medication record was what was administered to resident #001.

On an identified date, RN #106 documented a routine dose of specified medication for resident #001.

During interview with Inspector #194, RN #106 reviewed the documentation and was unable to recall if the specified medication had been given to resident #001 as documented.

The licensee failed to ensure that resident #001's routine dose of a specified medication was administered as prescribed when the as needed dosage of the specified medication was documented as given on an identified date by RPN #111 and on another date, by RN #106. [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 by ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 5th day of March, 2020

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

Original report signed by the inspector.