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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347 Preston St Suite 420
OTTAWA ON K1S 3J4
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347 rue Preston bureau 420
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 8, 2018	2017_619550_0030	024729-17	Resident Quality Inspection

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 MEDEX
1865 BASELINE ROAD OTTAWA ON K2C 3K6

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

JOANNE HENRIE (550), MICHELLE EDWARDS (655), PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): December 18, 19, 20, 21, 22, 2017 and January 2, 3, 4 and 5, 2018.

Logs 015562-17, 010300-17, 025687-17, 014709-17, 022241-17and 028580-17 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Support Services Manager (SSM), the Dietary Manager, the Recreation Manager, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), the President of the Resident Council, the Vice President of the Resident Council, residents and family members.

In addition, the inspectors reviewed resident health care records, critical incident reports, medication incident reports and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, and a partial meal services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **4 WN(s)**
- **1 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_619550_0016	550

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 O.Reg 79/10, s. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Inspector #138 was touring the building on December 18, 2017, and recalled the elevator from a residential area on the third floor by pressing the down button. The inspector stepped into elevator #1, which is a resident accessible elevator, and noted that there was a white rectangular piece of plastic near the control panel on the inside of the elevator attached to the wall of the elevator by a small bolt at the top of the plastic. The inspector was able to rotate the white piece of plastic to reveal two additional buttons labelled GR and BR, later determined to stand for "ground rear" and "basement rear" respectively. The inspector selected the BR button and was taken by the elevator to the basement floor where the rear door of the elevator opened. The inspector stepped through the rear door into an area that had an unlocked door leading to the compressor room, an unlocked door leading to a stairwell, two unlocked doors leading to separate storage areas, and an unlocked door to a supply room containing various cleaning chemicals.

The next day, Inspector #138 recalled the elevator from a residential area on the second floor. Elevator #1 arrived at the second floor, the inspector entered the elevator and again rotated the piece of white plastic to reveal the GR and BR buttons. This time on the elevator, the inspector selected the GR button and was brought to the ground floor where the rear doors of the elevator opened. The inspector went through these doors into an area that had an opened door to a housekeeping closet with cleaning supplies, the staff room, an exit door, an office, and the kitchen.

Inspector #138 also noted that elevator #1 was accessible by residents on the ground floor. Residents from all floors which includes ground, second, and third can access elevator #1 and once inside can access the GR and BR buttons on the elevator, leading to the areas described above.

On December 20, 2017, Inspector #138 met with the Support Services Manager and toured elevator #1 as well as the areas on the ground floor and the basement floor described above that were accessed through the GR and BR buttons respectively. The Support Services Manager stated that these areas are not to be accessed by residents and also stated that the elevators are not set up to restrict resident access to these area.

As such, the licensee has failed to ensure that elevator #1 is equipped to restrict resident access to areas on the ground floor and basement floor that are not meant to be accessed by residents.

This non-compliance represents a potential risk that is widespread as it affects all residents in the home. [s. 10. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 of care was provided to resident #026 as specified in the plan.
A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Homes Act, 2007, on a specified date in 2017, related to an incident involving resident #026 and resident #027.

According to the CIR, resident #026 was observed by staff to have a behaviour of sexual nature in the presence of a co-resident at 1930 hours on a specified date in 2017.

Inspector #655 reviewed the health care record belonging to resident #026, including electronic and hard-copy records.
According to the progress notes, resident #026 had behaviours of a sexual nature in the presence of staff and or co-residents on five other occasions in a specified two month period in 2017.

In a progress note on a specified date, a Behavioural Support (BSO) staff recommended the use of a specified type of garment to prevent recurrence of the above-described behaviour which was first observed on a specified date in 2017. In progress notes dated on two specified dates in 2017, the psychogeriatric nurse also recommended the use of this specified type of garment.

In a progress note dated on a specified date in 2017, RN #101 described the incident that occurred on that same day, as indicated in the CIR submitted to the Director under the LTCHA, 2007. According to the progress note, resident #026 had a behaviour of a sexual nature in the presence of co-resident #027. In the note it indicates that staff intervened and that resident #026 was "assisted to lift his pants up", and was then redirected to an activity. In the same note it stated that two of resident #026's family members were contacted and notified to "deliver a specified type of garment". It further stated that RN #101 borrowed a specified type of garment to put on resident #026 immediately after the incident.

In resident #026's hard copy health care record, Inspector #655 reviewed a physician's order a specified date in 2017. The order indicated that resident #026 is to wear a specified type of garment in order to prevent inappropriate undressing and behaviours. Inspector #655 reviewed resident #026's care plan. According to the care plan, the above-described special type of garment intervention was added to the care plan over four weeks after the order was received; and after the second incident occurred.

During an interview on January 5, 2017, RN #101 indicated to Inspector #655 that she was working at the time the incident occurred. She was unable to recall whether resident #026 was wearing the specified type of garment at the time of the incident. The RN reviewed the physician's order in which the use of a specified type of garment was prescribed and she acknowledged that the intervention was not added to the care plan at that time. According to RN #101, the intervention would not have been added at the time of the order if the staff did not have access to the specified type of garment at that time.

During an interview on January 5, 2017, the DOC indicated to Inspector #655 that resident #026 was not wearing the specified type of garment at the time of the incident, although it was part of the resident's plan of care at the time. The DOC reviewed the physicians order and indicated to Inspector #655 that the order was initially a recommendation made by the psychogeriatric nurse; and that once it was approved by the physician, the intervention was considered to be part of resident #026's plan of care. According to the DOC, the plan of care was not implemented at the time of the incident, when the specified type of garment was not utilized for resident #026. The DOC indicated to Inspector #655 that staff were aware that at the time of the incident, resident #026 was expected to be wearing a specified type of garment.

The licensee failed to ensure that the care set out in the plan of care was provided to

resident #026 as specified in the plan of care, when the identified intervention of a specialized garment was not implemented to prevent incidents of inappropriate behaviours. [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 resident #026 as specified in the plan,, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident have their personal items, including personal aids such as dentures, glasses and hearing aids, cleaned as required.

On December 19, 2017, during the observation of resident #003, inspector #550 noted the top of the backrest and the seat cushion of the resident's wheelchair to be soiled with dust, debris and splatters of a whitish dried matter. On January 2, 2018, the inspector conducted a subsequent observation which revealed the same uncleanliness of the wheelchair.

During an interview, RPN indicated to inspector #550 that cleaning of resident's mobility equipment is done and documented by the night PSWs in the "wheelchair cleaning schedule" which is kept in the "wheelchair cleaning schedule and mobile lift audit 3rd floor" binder.

The inspector reviewed the PSW job routines for the 3rd floor and noted documented that the PSW on each wing is responsible for cleaning the mobility equipment for the residents according to the schedule. The inspector then reviewed the cleaning of ambulation of equipment schedule. According to this schedule, the cleaning of the ambulation equipment for resident #003's room number was to be done on December 1 and 18, 2017. The document was signed by the PSW on December 1st but there was no signature for December 18.

On January 3, 2018, inspector #550 interviewed the DOC. She indicated that an external company comes to the home twice per year to do a thorough cleaning of the resident's mobility equipment and that between this cleaning, the night PSWs are responsible to clean the resident's mobility equipment twice per month as per the established schedule. All other PSWs are expected to clean any spills as required. The DOC reviewed the wheelchair cleaning schedule for the 3rd floor and confirmed that resident #003's wheelchair was scheduled to be cleaned on December 1 and 18, 2017. She further indicated that the document was not signed on December 18 by the night PSW and that because of the current state of the wheelchair, resident #003's wheelchair had not been cleaned on December 18, 2017 as scheduled.

As evidenced, resident #003's wheelchair was not cleaned when required. [s. 37. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee specifically failed to ensure that:
(b) corrective action is taken as necessary, and
(c) a written record is kept of everything required under clauses (a) and (b).

Inspector #550 reviewed the home's medication incident reports for the last quarter which included the months of July, August and September, 2017. It was documented that in July there were two medication incidents where one resident received the wrong dosage of a specific medication and another resident did not receive a specific medication as prescribed by the physician. There were no medication incidents documented in August. In September there were two medication incidents documented where two residents in the same room received the other resident's medication. It was noted by the inspector that there was no corrective actions documented by the previous DOC on all of the four incident reports.

On January 3, 2017, during an interview, the Administrator indicated to the inspector that she would need to contact the home's previous DOC to find out where she documented the corrective actions taken in regards to the medication incidents for the incidents that occurred in July and September.

On January 5, 2017, the new DOC indicated to the inspector that the Administrator had informed her that the previous DOC would hand write the corrective actions taken on each of the medication incident reports. She further informed her that if there was no corrective action documented the medication incident reports by the previous DOC, this indicated that no corrective actions had been taken to date.

The inspector reviewed the above medication incident reports with the new DOC and noted that there were no corrective actions documented for these incident reports.

As evidenced, corrective actions were not taken and documented for the medication incidents which occurred in July and September 2017. [s. 135. (2)]

Issued on this 15th day of February, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550), MICHELLE EDWARDS (655), PAULA MACDONALD (138)
Inspection No. / No de l'inspection :	2017_619550_0030
Log No. / No de registre :	024729-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 8, 2018
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE MEDEX 1865 BASELINE ROAD, OTTAWA, ON, K2C-3K6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tina Nault

To EXTENDICARE (CANADA) INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Order / Ordre :

The licensee shall ensure that elevator #1 is equipped to restrict resident access to the rear corridor on both the ground floor and the basement.
While elevator #1 is not equipped to restrict resident access to the rear corridor on both the ground floor and the basement, the licensee must take immediate action to mitigate safety risks related to the unrestricted access to these areas by residents.

Grounds / Motifs :

1. The licensee failed to comply with section 10.(1) of the regulation in that the licensee failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.

Inspector #138 was touring the building on December 18, 2017, and recalled the elevator from a residential area on the third floor by pressing the down button. The inspector stepped into elevator #1, which is a resident accessible elevator, and noted that there was a white rectangular piece of plastic near the control panel on the inside of the elevator attached to the wall of the elevator by a small bolt at the top of the plastic. The inspector was able to rotate the white piece of plastic to reveal two additional buttons labelled GR and BR, later determined to stand for "ground rear" and "basement rear" respectively. The inspector selected the BR button and was taken by the elevator to the basement floor where the rear door of the elevator opened. The inspector stepped through the rear door into an area that had an unlocked door leading to the compressor room, an unlocked door leading to a stairwell, two unlocked doors leading to separate storage areas, and an unlocked door to a supply room containing various cleaning chemicals.

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As such, the licensee has failed to ensure that elevator #1 is equipped to restrict resident access to areas on the ground floor and basement floor that are not meant to be accessed by residents.

This non-compliance represents a potential risk that is widespread as it affects all residents in the home. (138)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 03, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 8th day of February, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

Service Area Office /
Bureau régional de services : Ottawa Service Area Office