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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 4, 2017	2017_682549_0005	009602-17, 009838-17	Complaint

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 NEW ORCHARD LODGE
99 NEW ORCHARD AVENUE OTTAWA ON K2B 5E6

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

RENA BOWEN (549)

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): September 11, 12, 13, 14, 15, 2017

Log # 009839-17 -related to improper/incompetent treatment of a resident was inspected concurrently.

During the course of the inspection, the inspector(s) spoke with a resident, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), a Physician, a Pharmacist, the Pharmacy Consultant, the Assistant Director of Care (ADOC), the Director of Care (DOC) and the Administrator.

The inspector reviewed a resident's health care file including the electronic Medication Administrator Records (eMARS), physician's orders, pharmacy delivery drug records, staffing schedules and specific licensee medication policies.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 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. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the following rights of residents are fully respected and promoted: iv. that resident #001's Substitute Decision Maker (SDM) for care had access to the resident's records of health information, including the resident's plan of care in accordance with the Personal Health Information Protection Act, 2004.

Resident #001 was admitted to the home on a specific date. The resident was diagnosed with Frontal Lobe Dementia. The Minimum Data Set assessment dated a specific date in 2017 indicated that resident #001's cognitive skills for daily decision-making is moderately impaired - decisions poor; cues or supervision required. The resident does not communicate with the direct care staff or others.

During an interview with the Administrator and Director of Care (DOC) on September 11, 2017 it was indicated to Inspector #549 that resident #001's SDM makes all of the care decisions for the resident.

During a telephone interview with resident #001's SDM on September 11, 2017 it was indicated to Inspector #549 that on a specific date in 2017 the SDM requested that the

Registered Nurse (RN) read resident #001’s attending physician’s documentation and electronic Medication Administration Records (eMARs) over the phone. The SDM indicated that he/she requested the resident's personal health information to be able to participate in the resident's treatment plan. The resident had been diagnosed with a specific medical condition on a specific date in 2017. The SDM indicated to the inspector that he/she was not able to travel to the home.

During the same telephone interview the SDM indicated that he/she was informed by the RN in Charge on a specific date in 2017, that the home does not provide personal health information over the telephone. The SDM indicated that he/she provided the home with a secured email address however, the RN in Charge also indicated that the home would not email personal health information. The SDM indicated that on a specific date in 2017 the RN in Charge did not offer any other form of communication so that he/she could receive the requested information in a timely manner.

During an interview with the Assistant Director of Care (ADOC) and the DOC on September 11, 2017 it was indicated to the inspector that the home does not provide personal health information over the telephone and it is not their practice to use email.

The ADOC indicated that during a specific week in 2017, the SDM was offered to have the eMARs faxed to the SDM. Which was several days after the request was made by resident #001’s SDM.

The licensee failed to ensure that resident #001’s rights where fully respected and promoted in not providing access to resident #001’s SDM records of personal health information, including the resident’s plan of care, in accordance with the Personal Health Information Protection Act, 2014 on a specific date in 2017. [s. 3. (1) 11. iv.]

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 resident #001's rights are fully respected and promoted in providing the SDM access to resident#001's records of personal health information, including the resident's plan of care, in accordance with the Personal Health Information Protection Act, 2004, to be implemented voluntarily.

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide care to the resident.

Resident #001 was admitted to the home on a specific date in 2017. The resident was diagnosed with Frontal Lobe Dementia. Minimum Data Set assessment dated a specific date in 2017 indicated that resident #001's cognitive skills for daily decision-making is moderately impaired - decisions poor; cues or supervision required. The resident does not verbally communicate with the direct care staff or others.

Inspector #549 reviewed the resident's progress notes which indicated that the resident was diagnosed with an medical condition on a specific date in 2017 and then diagnosed with a different medical condition on a specific date in 2017.

The Minimum Data Set (MDS) assessment for resident #001 dated a specific date in 2017 indicated that the resident required extensive assistance with one person physical assist with personal hygiene- including combing hair, brushing teeth, applying makeup, washing/drying face.

The inspector reviewed the current plan of care last reviewed a specific date in 2017 which indicated that the resident has a potential for specific complications: has a history of a specific medical condition. Interventions state: monitor and report changes to registered staff immediately. Assist the resident when required with Activities of Daily Living (ADLs).

During an interview with PSW #115 on September 13, 2017 it was indicated to Inspector #549 that the PSW washes resident #001 specific body part with a face cloth each day as part of the residents morning care and removes any dried discharge. PSW #115 is a full time PSW who works on resident #001's unit and is assigned to provide care to resident #001.

During the same interview PSW #115 reviewed resident #001's plan of care on Point of Care (POC) with the inspector and indicated that there is no clear direction as to how to provide this specific care to resident #001 and indicated that she was not given any verbal instructions from the registered staff.

The licensee has failed to ensure the plan of care sets out clear direction related to the

specific daily hygiene care of resident #001 [s. 6. (1) (c)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of resident #001 so the their assessments are integrated, consistent with and complement each other.

Resident #001 was admitted to the home on a specific date in 2017. The resident has been diagnosed with Frontal Lobe Dementia. Minimum Data Set assessment dated a specific date in 2017 indicated that resident #001's cognitive skills for daily decision-making is moderately impaired - decisions poor; cues or supervision required.

During an interview with the Administrator and DOC on September 11, 2017 it was indicated to Inspector #549 that resident #001's SDM makes all of the care decisions for the resident.

Inspector #549 reviewed resident #001's physician orders for a specific date in 2017, which indicated that the resident was prescribed three different types of medication to treat a specific medical condition.

During an interview with the ADOC on September 11, 2017, it was indicated that on a specific date in 2017 it was noted that one of the medications was not available. The ADOC indicated that the SDM was notified when he/she called the home for an update on a specific date in 2017 that the specific medication have not been available since being prescribed on an earlier specific date in 2017.

During a telephone interview with resident #001's SDM on September 11, 2017 it was indicated to Inspector #549 that the SDM had requested that the attending physician be contacted and be informed of the SDM's concerns related to resident #001 not receiving all of the prescribed medications. The SDM indicated that he/she was concerned as the resident was diagnosed with a specific medical condition on a specific date in 2017, however the resident started having visible symptoms on an earlier specific date in 2017. The SDM indicated to the inspector that he/she was informed by the home that the resident was refusing the medication at times due to behaviours and that a specific medication had not been received by the home. The SDM indicated that he/she requested that the RN in Charge call the attending physician and inform the physician of the medication refusal due to behaviours and that the specific medication was not available. The SDM indicated that the registered staff did not call the attending physician when asked by the SDM on a specific date in 2017.

During an interview with the ADOC on September 11, 2017 it was indicated to the inspector that the registered staff did not notify the attending physician at the request of resident #001's SDM.

During an interview with resident #001's attending physician it was indicated to Inspector #549 that he was not notified that the resident's SDM was concerned about resident #001's medication and wanted him to be notified.

The licensee failed to ensure care collaboration with the physician in the assessment of resident #001 so that their assessment are integrated, consistent with and complement each other when the RN in Charge did not contact the physician on a specific date in 2017 related to resident #001's medication not be available and the refusal of some medications. [s. 6. (4) (a)]

3. The licensee has failed to ensure that the plan of care for resident #001 was revised when the resident's care needs changed.

Inspector #549 reviewed resident #001's progress notes for a specific month in 2017. The progress notes dated a specific date in 2017 indicated that the resident's specific body part was slightly pink, no discharge noted. On a specific date in 2017 the progress notes indicated that the resident's specific body part was red, watery, no discharge noted, resident was making facial grimace. A warm compress was applied, the area remained red and watery. The resident's attending physician was notified of resident #001's change of condition.

The resident's physician notes indicated that the attending physician diagnosed the resident with a specific medication condition and ordered medication on a specific date in 2017.

The residents progress notes dated a specific date in 2017 indicated that resident #001's SDM informed the home on an earlier specific date in 2017 that the resident has had a long history of the specific medical conditions. The progress notes indicated that resident #001 was seen at a specific clinic on a specific date in 2017.

Resident #001's care needs change on a specific date in 2017 when the resident was diagnoses with a specific medical condition and again when the resident was diagnosed with a different medical condition on a specific date in 2017.

Inspector #549 reviewed the written plan of care, last review completed date on a specific date in 2017. The written plan of care was not updated to identify resident #001'specific medical condition until forty six days after resident #001 was diagnosed and forty eight days after the SDM informed the registered staff of resident #001's history of the specific medical conditions.

The license failed to update resident #001's plan of care when the resident was diagnosed with a specific medical condition or when the resident was diagnosed with a different medical condition. [s. 6. (10) (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 resident #001's plan of care sets out clear direction to staff and others who provide care to the resident, that resident #001's plan of care is revised when the resident's care needs change and ensure staff and other collaborate so that their assessments are integrated, consistent with and complement each other, 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 had failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place is complied with.

O. Reg. 79/10 s.114(2) requires the licensee to have written policies and protocols developed for the medication management system to ensure that accurate acquisition, dispensing receipt, storage, administration and destruction and disposal of all drugs used in the home.

The licensee's policy # 3-6 titled Medication Pass, dated February 2017 was reviewed by Inspector #549. The policy indicates under Procedure: bullet six: Administer medications and ensure that they are taken. Document on the MAR in proper space for each medication administered or document by code if medication is not given.

The eMAR codes are as follows: 2=Drug refused, 7=sleeping, 9=other/see Nurse Notes, 10=drug not available.

Resident #001 was prescribed a specific medication at bed time, a different specific medication every hour and another different medication three times a day on a specific day in 2017.

Inspector #549 reviewed resident #001's electronic Medication Administration Record (eMAR) for a specific month in 2017. The eMAR for that specific month indicated that the resident received the first dose of one of the medications at 2100 hours on a specific date in 2017. The eMAR also indicated to "see nursing notes" for the 2100 hour administration of a specific medication every hour.

Resident #001's progress notes dated a specific date in 2017 where reviewed by Inspector #549 and indicated that the first doses of medications where administered to the resident upon receiving them from pharmacy but unable to administer next doses as unable to wake resident up from sleep. The eMAR does not indicate that the resident received the dose of medication at 2100 hours. There is no documentation on the eMAR for the 2200 hour dose of the other specific medication.

The eMAR did not have an entry for the administration of the specific medication to the resident #001 every hour when awake on the following dates and times: on a specific date in 2017 at 0600 hours, on specific different date in 2017 at 2200 hours, on a specific different date in 2017 at 2200 hours, on a specific different date in 2017 at 0600 hours, on different specific date in 2017 at 0400 hours and 0600 hours, and on a specific different specific date at 2200 hours.

There is an entry on the eMAR indicating to see nursing notes for two specific dates in 2017, for the dose of medication to be given at bedtime. Inspector #549 reviewed the nursing notes for those specific dates. The progress note for the specific date in 2017 indicates that a message was left for the SDM regarding an update of the resident's appointment the previous day and the decrease in the times of the medications. There is no entry in the eMAR or progress note indicating if the medication was administered at bed time on a specific date in 2017.

The progress notes for a specific date in 2017 indicated that the resident received the medication at bedtime. The eMAR does not have an entry indicating that the medication was administered.

On September 12, 2017 during an interview with the DOC it was indicated to Inspector #549 that the home's expectation is that when a resident has refused a medication, is sleeping and does not receive it or any other reason it should be entered into the eMAR by the registered staff.

The licensee has failed to ensure compliance with their Medication Administration policy # 3-6 titled Medication Pass dated February 2017. [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 all registered staff comply with the licensee's Medication Pass policy #3-6 last updated February 2017, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is reviewed and, if required, revised. O. Reg. 79/10, s. 29.

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident is reassessed and the resident's plan of care is reviewed and revise under subsection 6(10) of the Act, consent or directive with respect to "treatment" as defined in the Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or "plan of treatment" or a "plan of treatment" under that Act, that is relevant is reviewed and, if required, revised.

Resident #001 is moderately cognitively impaired as indicated in the Minimum Data Set assessment dated a specific date in 2017and is unable to communicate with direct care staff or others.

During an interview with the Administrator and the Director of Care on September 11, 2017 it was indicated to the inspector that the resident's SDM for care makes all of the resident's care decisions.

Resident #001's progress notes reviewed by Inspector #549 for a specific period in 2017 indicated that the resident's specific body part was slightly pink on a specific date in 2017. The attending physician prescribed a medication for the resident's specific body part that was noted to be red. The RPN also indicated in the progress notes that the resident's specific body part was swollen. On a specific date in 2017 the attending physician diagnosed the resident with a specific medical condition and prescribed a medication for treatment.

Inspector #549 was unable to locate any documentation that indicated that the SDM was notified by the home on a specific date in 2017 of the change of condition of resident

#001 specific body part or the change in the resident's treatment plan.

During a telephone interview with the SDM on September 11, 2017 it was indicated to Inspector #549 that he/she was not aware of the change in resident #001's condition which was documented to have started on a specific date in 2017 or the change in the treatment plan until a later date in 2017. The SDM indicated that he/she received notification of the change of condition of resident #001 and a new treatment plan from the licensee's contracted pharmacy. The contracted pharmacy called the SDM requesting approval of payment for the medication that had been prescribed for resident #001's medical condition.

The SDM also indicated during the telephone interview on September 11, 2017 that he/she was not informed on a specific date in 2017 that the "treatment plan" for resident #001 was changed due to a specific medication not being available for three days.

During an interview with the attending physician on September 12, 2017,it was indicated to the inspector that he was not notified by the home that the specific medication would not be available for three days.

During an interview on September 15, 2017, RN #100 indicated to the inspector that she did not notify the attending physician on a specific date in 2017 that the medication would not be available for three days. RN #100 also indicated that she did not notify the SDM that the specific medication would not be available for three days.

The licensee failed to receive consent or directive with respect to a "course of treatment" or "plan of treatment" when resident #001 was diagnosed with a medical condition on a specific date in 2017 and when medication was prescribed and when the "treatment plan" changed when resident #001's specific medication was not available for three days on a specific date in 2017 . [s. 29.]

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 when a resident is reassessed and the resident's plan of care is reviewed and revised consent or directive is received with respect to a "course of treatment" or "plan of treatment" as defined in the Health Care Consent Act, 1996, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established and maintained and kept in the home for at least two years, in which the following information is recorded in respect to every drug that is ordered and received in the home.

The ADOC indicated to Inspector #549 during an interview on September 11, 2017, that

the licensee's contracted pharmacy is Medical Pharmacies.

Review of resident #001's physician order's indicated that resident #001 was prescribed three different types medication on a specific date in 2017. The home received two of the three medications on a specific date in 2017 during the evening shift (1500 hours to 2300 hours).

During an interview with RN #100 on September 15, 2017 it was indicated to Inspector #549 that she was working the evening shift on a specific date in 2017 when resident #001's medications where delivered by the pharmacy. RN #100 indicated that she does not recall receiving the medication but does indicated that she thinks one of the medications may not have been delivered.

Inspector #549 reviewed resident #001's health care file and located a pink slip dated a specific date in 2017 from Medical Pharmacies indicating that one of the ordered medications would not be available for delivery for between 1 to 3 days.

During an interview with the ADOC on September 15, 2017 it was indicated to Inspector #549 that when the home receives a drug from medical pharmacy it is scanned to MEDelink Medication Portal in PCC. The registered staff are then able to print a medication Receiving Detail report that contains O. Reg. 79/10 s.133 legislative requirements.

Inspector #549 reviewed the medication Receiving Detail report for resident #001's specific medication. The medication Receiving Detail report showed that a specific medication was "deferred". The inspector was unable to locate any documentation that had the electronic signature of the person acknowledging the receipt of the drug on behalf of the home and the date the drug was received.

The ADOC indicated during an interview on September 15, 2017 that there have been times when a medication is delivered and the bar scan does not scan properly when it is received. If the bar scan does not work the medication Report Detail report will not provide the electronic signature of the person acknowledging the receipt of the drug on behalf of the home or the date of the delivery.

The licensee has failed to ensure that when using the MEDelink system to scan drugs received that the signature of the person receiving drugs and the date that the drugs are delivered is recorded and kept in the home for at least two years. [s. 133.]

Issued on this 5th day of October, 2017

[redacted]

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

Original report signed by the inspector.