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

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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 5, 2020	2020_683126_0007	001433-20, 002622-20	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 New Orchard Lodge
99 New Orchard Avenue OTTAWA ON K2B 5E6

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

LINDA HARKINS (126)

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): February 25, 26, 27, 28, March 2, 2020.

During this inspection, the following logs were inspected:
Log #001433-20 (Critical Incident (CI) #2302-000001-20 and log#002622-20 (CI #2302-000003-20) related to an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Physiotherapist, several Registered Nurses (RNs), several Registered Practical Nurses (RPNs), several Personal Support Workers(PSWs) and several residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Pain

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, ii. that is secure and locked.

1)On the afternoon of February 25, 2020, Inspector #126 was walking toward a specific resident room, when they noticed a medication cart that was left unlocked and unattended. The Inspector was able to open the firs drawer of the medication cart, looked around and was unable to locate a nurse within the vicinity of the medication cart.

Down the hallway, two Personal Support Workers told the nurse who was in room 219 that someone was touching the medication cart. RPN #100 came running to the cart and indicated that she had to attend to a resident and did not locked the medication cart at that time. The RPN indicated that they were aware that the medication cart was to be locked at all time.

The licensee failed to ensure that the medication cart was kept locked at all time.

2) The next day, on February 26, 2020, at the start of the evening shift, Inspector #126 was walking on the unit and noticed that a medication cart was left unlocked and unattended in front of a stairwell. Inspector #126 was able to open the first drawer of the medication cart when a resident yelled that it was locked. At that time, RPN #102 who was in front of the Quality Indicator Coordinator ‘s Office, turned their back and walked back to the medication cart.

RPN #102 indicated that they were aware that the medication cart was to be lock at all time.

The licensee failed to ensure that the medication cart was kept locked at all time. [s. 129. (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 to ensure that drugs are stored in an area or a medication cart,
ii. that is secure and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was protected from verbal abuse from Personal Support Worker (PSW) #116.

As per O. Regs 79/10, s. 2.(1), “verbal abuse” means (a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

On March 2, 2020, Inspector #126 was walking down the hallway and overheard PSW #116 saying to resident #004 that they were going to throw them in the river or in the snow if they didn’t stop yelling.

Discussion held with PSW #116 who indicated that they were just playing with the resident and that it didn’t mean anything.

Discussion held with resident #004 who indicated to Inspector #126 that they were afraid when they were told they would be thrown in the river or snow and asked Inspector to please not throw her/him anywhere.

A Private Care Giver, who was sitting in the hallway, overheard PSW#116 telling the resident that they were going to throw them in the river or the snow if they would not stop yelling.

The licensee failed to ensure that resident #004 was protected from verbal abuse from PSW #116. [s. 19. (1)]

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.