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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 27, 2017	2017_598570_0010	002659-17	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 PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

SAMI JAROUR (570), CRISTINA MONTOYA (461), JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 03-07 and 10, 2017

Resident Quality Inspection (RQI) #002659-17. The following intakes were reviewed and inspected concurrently with the RQI, intakes #034770-16, #004970-17, #006829-17, #032822-16, and #026414-16.

Summary of Intakes:
1) Log #034770-16 - Critical Incident Report - Medication Error;
2) Log #004970-17 - Critical Incident Report - alleged resident to resident sexual abuse;
3) Log #006829-17 - Critical Incident Report - incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status;
4) Log #032822-16 - Critical Incident Report - incident that causes an injury to a resident for which resident is taken to hospital and which results in a significant change in resident's health status; and
5) Log #026414-16 - Complaint - responsive behaviours;

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI-Coordinator, Clinical Coordinator and IPAC Lead, Programs Manager, Dietitian (RD), Dietary Aides, Cook, Rehabilitation Assistant, Environmental Services Manager (ESM), President of Family Council, President of Residents' Council, Families, and Residents.

During the course of this inspection, the inspector(s) toured the home, reviewed clinical health records, observed resident to resident interactions, staff to resident interactions, and observed medication administration; reviewed Residents' Council meeting minutes, reviewed medication incidents and adverse drug reactions, licensee's investigational notes and the licensee's skin and wound program policy.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 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	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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A review of resident #034's Medication Administration Record (MAR) of a specified month, indicated that resident #034 had orders in place for four identified medications to be administered at 1700 hours.

A Medication Incident Report was completed on specified date, by RN #118 which indicated that on the same date, at 1700 hours, RPN #123 had administered resident #034's 1700 hours medications to resident #033. The resident received another resident's medication that was not ordered by the Physician.

In an Interview with RPN #123 on April 5, 2017, the RPN admitted to administering the incorrect medications to resident #033. The RPN further indicated that resident #033 was assessed, as well as, the Physician and the SDM were notified of the Medication Incident that occurred on a specified date. The RPN also indicated the resident was monitored during the shift, and had no adverse reactions as a result of the incorrect medications given.

RPN #123 had administered resident #034's 1700 hours medications to resident #033. The resident received another resident's medication that was not ordered by the Physician. [s. 131. (1)]

2. Related to Intake Log #034770-16:

A Critical Incident Report (CIR) was submitted to the Director on a specified date, related to a medication incident resulting in an adverse drug reaction that occurred one day prior.

The CIR indicated that RPN #113 mistook a resident for another resident, had checked the Electronic Medication Administration Record (EMAR) picture and felt he/she had the right resident. The resident was given two identified medications.

A review of resident #038's Medication Administration Record (MAR) of a specified month, indicated that resident #038 had orders in place for three medications to be administered at 1700 hours.

A Medication Incident Report was completed on the day of the incident, by RPN #113 which indicated that on the same date, at 1700 hours RPN #113 had administered resident #038's 1700 hours medication to resident #037. The resident received another

resident's medication that was not ordered by the Physician.

Interview with RPN #113 on April 4, 2017, indicated that on the date of the incident, he/she had administered resident #038's medication to resident #037 and did not realize that until he/she had gone to administer resident #037's medication. The RPN indicated as soon as he/she identified that there was an error, he/she contacted RN #114 and notified him/her of the incident. The RPN indicated him/her and RN #114 monitored the resident, contacted resident #037's Substitute Decision Maker (SDM) and notified the Physician, but was not sure if the pharmacy provider was notified of the incident.

Resident #037 was administered resident #038's medication that was not ordered by the Physician, resulting in the resident having an adverse reaction and had to be transferred to hospital for further assessments. [s. 131. (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 no drug is used by or administered to any resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #2: 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. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

Review of resident #031's Medication Administration Record (MAR) of a specified month, indicated that resident #031 had an order in place for pain medication to be administered three times daily. Further review of resident #031's MAR, indicated that on an identified date, RPN #134 had signed the MAR as having administered the medication.

A Medication Incident Report was completed on same day, by RPN #107, which indicated that RPN #134 had signed that he/she had administered the pain medication to resident #031, but the medication was not administered to the resident.

Further review of the Medication Incident Report indicated that a note was left on the Physician clipboard to notify the Physician of the incident.

A review of the progress notes had no documented record that an assessment of the resident was completed on or after the incident.

Interview with RPN #134 on April 10, 2017, indicated that he/she learned of the medication incident on the next day of his/her schedule shift and indicated that the DOC did speak to him/her about the incident. The RPN further indicated that he/she had signed for administering the above identified medication to resident #031, but the medication was not administered. The RPN #134 was not sure if the pharmacy was notified as he/she did not fill out the Medication Incident Report, another staff did.

Interview with RPN #107 on April 10, 2017, who discovered the incident, indicated he/she had taken over the medication pass from RPN #134 the day the incident occurred, when he/she noticed that resident #031's pain medication at 0800 hours dose was not administered. RPN #107 indicated that he/she filled out a Medication Incident Report and had expected that RN #109 would have documented an assessment for

resident #031. RPN #107 indicated that he/she did not assess resident #031. RPN #107 indicated that the Medication Incident Report was given over to the DOC and he/she did not fax the report to the pharmacy.

Interview with the DOC indicated it is the nurse's responsibility to fax the Medication Incident Reports to the Pharmacy. [s. 135. (1)]

2. Review of resident #032's Medication Administration Record (MAR) of a specified month, indicated that on a specified date of the month, RPN #135 had signed the MAR as having administered a specified medication to resident #032 at specified time.

A Medication Incident Report was completed on the same date by RPN #135 which indicated that the RPN administered the wrong dose of the specified medication to resident #032. Review of resident #032's Medication Administration Record (MAR) of same specified month, indicated that resident #032 had an order in place for a specified medication to be administered a specified dose of the medication.

Interview with RPN #135 on April 5, 2017, indicated that he/she self-reported the above identified incident and did perform increase monitoring of the resident that shift, but did not document this in the progress notes as he/she was unsure of where to document the incident.

Resident #032 received the wrong dose of a specified medication in excess of what was ordered by the physician. [s. 135. (1)]

3. A review of resident #035's Medication Administration Record (MAR) of a specified month, indicated that resident #035 had orders in place to administer pain medication at specified time.

A Medication Incident Report was completed on specified date by RPN #136 which indicated that resident #035 was administered two separate doses of pain medication. The incident report indicated that a note was left on the physician's clipboard to notify the physician of the incident.

During an interview with RPN #113 on April 6, 2017, he/she indicated that on the date of the incident he/she administered resident #035's pain medication at specified time, but did not document the administration in Point Click Care (PCC) or the narcotic book. That same date, RPN #136 administered an additional dose of the pain medication to resident

#035 after RPN #113 shift had ended. Resulting in resident #035 receiving two doses of the pain medication with no adverse effect.

Interview with the DOC on April 5, 2017, indicated that RPN #136 no longer works at the home, and it is the nurse's responsibility to fax the Medication Incident Reports to the Pharmacy. [s. 135. (1)]

4. A review of resident #036's Medication Administration Record (MAR) of an identified month, indicated that resident #036 had orders in place to administer an identified medication once weekly for four weeks. Further review of the Medication Administration Record (MAR) of the same month, indicated that resident #036 was administered the above identified medication on five consecutive days of the identified month.

A Medication Incident Report was completed on an identified date, by RPN #137, which indicated that resident #036 was administered five separate doses of their identified medication daily for five consecutive days, instead of once weekly.

Interview with RN #118 on April 5, 2017, indicated that he/she had transcribed the order for the above identified medication to be administered daily instead of once weekly and the order was also second checked by another nurse and neither nurses who checked the order had identified the transcription error.

Interview with RPN #137 on April 6, 2017, indicated he/she discovered the above identified incident and brought it forward to the DOC's attention and indicated the resident was assessed, the resident's SDM was notified as well as the physician and the resident had no adverse reaction as a result of the medication incident. There was no documentation that the incident report was faxed to the pharmacy provider.

A transcription error was made related to the time resident #036 should have been administered an identified medication, resulting in the resident being administered the medication daily for five consecutive days, instead of once weekly. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident-staff communication and response system is available in every area accessible by residents.

During the initial tour of the home on April 3, 2017, at 1030 hours, Inspectors #607 and #461, observed the exercise room located on the second floor on the Orchard Trail home area to be unlocked and have no resident-staff communication and response system. On April 5, 2017, at 1020 hours, Inspector #607 observed 12 residents in the above mentioned exercise room performing exercises.

In an interview with Rehabilitation Assistant staff #102, by Inspector 607 on April 3, 2017, he/she indicated residents do use the exercise room and further indicated there was no resident-staff communication and response system located in the exercise room.

On April 5, 2017, interview with the Environmental Service Manager (ESM) indicated that Orchard Trail exercise room is a resident area and further indicated the Orchard Trail home area resident-staff communication and response system are now being re-installed and indicated he/she will ensure that a communication and response system be installed in the exercise room. [s. 17. (1) (e)]

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. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the licensee's investigation related to the allegation of resident to resident sexual abuse were reported to the Director.

Related to Intake Log #004970-17:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on a specified date. The DOC indicated in the CIR that an incident of alleged resident to resident sexual abuse, involving residents #029 and #030, was reported to have occurred on same specified date.

Review of the CIR report indicated that the incident was discovered by a PSW staff and was immediately investigated on the same day. The CIR indicated that the DOC and the RPN spoke to both residents #029 and #030 in relation to the alleged incident.

On April 7, 2017, during an interview the DOC indicated that the incident was immediately investigated on the same day and concluded no findings of abuse.

Review of the CIR, the licensee's investigation and interview with the DOC indicated that the results of the licensee's investigation related to this incident of alleged sexual abuse had not been reported to the Director. [s. 23. (2)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #021 exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, the resident was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of the resident #021's clinical health records indicated that the resident had an area of altered skin integrity to an identified body part; this area was initially acquired on an earlier specified date. The resident also has two areas of altered skin integrity to two different identified body parts; both areas of altered skin integrity were acquired at an earlier specified date and were never resolved.

A review of the Resident Assessment Instrument - Minimum Data Set (RAI/MDS) assessments tool of a specified date indicated that resident #021 was coded as having an area of altered skin integrity to an identified body part and was later coded as worsened in the following quarterly assessment.

A review of the resident #021's progress notes and the home's Bates-Jensen - V 6 Weekly Wound Care Assessment tool, the tool that is used to complete weekly wound assessment, failed to identify documented evidence that weekly skin and wound assessments were completed for resident #021 for five identified dates.

A review of the home's policy #RC-06-12-01, titled Skin and Wound Program: Prevention of Skin Breakdown dated July 2016, page 1/9 directs:
All residents with a PURS score of > 1 will be considered at risk of alter skin integrity and receive a comprehensive head to toe assessment by a nurse:
- weekly for 4 weeks post-admission and monthly thereafter unless otherwise determined by the nurse after the initial assessment
- Upon change of condition that affects skin integrity

Interview with RN #116 on April 5, 2017, indicated the wound care nurse is responsible for conducting the weekly skin and wound assessments for residents with impaired skin integrity, and further indicated these are conducted using the home's Bates-Jensem-V6 wound care assessment tool in Point click care (PCC). RN #116 further indicated that he/she oversees skin and wounds impairments for the entire identified floor where resident #021 resides, and indicated that if the wound care nurse is away it is any registered staff responsibility to ensure these assessments are completed on residents with skin impairments. RN #116 further indicated that the home's expectation is that all wounds are assessed weekly using the Bates-Jensen Wound Care Assessment tool and further indicated that he/she was not able to locate that an assessment was completed for resident #021 on the above identified dates.

Interview with the DOC on April 5, 2017, indicated the home's expectation is that wound assessments are to be completed on residents who have altered skin integrity weekly. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, specifically related to resident #022.

A review of the Resident Assessment Instrument- Minimum Data Set (RAI-MDS) assessments record of an a specified date, indicated that resident #022 was coded as having impaired skin integrity and was later coded as having an area of altered skin integrity to an identified body part three months later.

A review of resident #022's clinical health records indicated that the resident had an area of altered skin integrity to an identified body part; this area was initially acquired on an identified date.

A review of resident #022's progress notes and the home's Bates-Jensen - V 6 Weekly Wound Care Assessment tool, the tool that is used to complete weekly wound assessment, failed to identify documented evidence that weekly skin and wound assessments were completed for resident #022 for ten identified dates.

RN #116 indicated that he/she oversees skin and wound impairments for the entire identified floor where resident #022 resides, and that if the wound care nurse is away it is any registered staff responsibility to ensure these assessments are completed on residents with skin impairments. RN #116 further indicated that the home's expectation is that all wounds are assessed weekly using the Bates-Jensen Wound Care Assessment tool, and further indicated that he/she was not able to locate that an assessment was completed for resident #022 on ten identified dates.

Interview with the DOC on April 5, 2017, indicated the home's expectation is that wound assessments are to be completed on residents who have altered skin integrity weekly. [s. 50. (2) (b) (iv)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure the report to the Director included the following description of the individuals involved with the incident, specifically did not include,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.

Related to Intake Log #004970-17:

The Director of Care (DOC) submitted a Critical Incident Report (CIR) to the Director on a specified date. The DOC indicated in the CIR that an incident of alleged resident to resident sexual abuse was reported to have occurred on and the same date.

Review of the CIR report indicated that the incident was discovered by a PSW staff and that the DOC and the RPN spoke to both residents #029 and #030 in relation to the alleged incident.

The CIR report did not include the name of the PSW staff who discovered the incident and did not include the name of the RPN who responded to the incident with the DOC.

On April 7, 2017, during an interview, the DOC indicated that the investigation into this incident indicated no findings of abuse. The DOC further indicated that PSW #133 discovered and reported the incident to RPN #123.

Review of the CIR and interview with DOC indicated that names of PSW #133 and RPN #123 were not indicated within the Critical Incident Report. [s. 104. (1) 2.]

Issued on this 28th day of April, 2017

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

Original report signed by the inspector.