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
Oct 2, 2020	2020_838760_0023	005122-20, 010540-20, 018627-20	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 Rouge Valley
551 Conlins Road TORONTO ON M1B 5S1

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

JACK SHI (760)

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): September 29, 30, October 1, 2, 2020.

The following intakes were completed in this critical incident inspection:

Log #005122-20, CIS report #2883-000013-20 was related to falls prevention;
Log #010540-20, CIS report #2883-000015-20 was related to an allegation of staff to resident physical abuse and neglect;
Log #018627-20, CIS report #2883-000020-20 was related to an allegation of staff to resident physical abuse.

During the course of the inspection, the inspector(s) spoke with the Associate Director of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

During the course of the inspection, the inspector conducted observations, interviews and record reviews.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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. 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 failed to ensure that their Medication Management policy included in the required medication program was complied with, for a resident.

Ontario Regulation 79/10, s.114 (2), indicates that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs are used in the home.

Specifically, staff did not comply with the home’s policy and procedure "Medication Management".

The Ministry of Long-Term Care (MLTC) received a Critical Incident Systems (CIS) report from the home where the SDM of a resident made an allegation of staff to resident physical abuse. Upon the home’s investigation, the home discovered that the resident had medications in their room. A review of the resident’s chart indicated they could not have medications in their room. The ADOC conducted an investigation and determined that the RPN did not follow the home’s medication administration policy as they did not observe the resident take their medications.

Sources: Resident's progress notes, medication administration record, plan of care; Medication Management policy (dated December 2019); interviews with RPN #103, RPN #105, ADOC #100 and other staff. [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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system; is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring techniques with two residents.

The MLTC received a CIS report related to a fall that a resident sustained and resulted in an injury. The resident's care plan indicates that two staff are required for a transfer, using a mechanical lift. A review of the home's investigation notes indicated three staff members manually lifted the resident after their fall, posing further risk of injury to the resident. The RPN stated they were unaware that the resident required a lift for transfers and confirmed they manually lifted the resident after their fall.

Sources: Resident's care plan; Falls Prevention and Management Program policy (dated December 2019); the home's investigation notes; interviews with an RPN and other staff. [s. 36.]

2. The MLTC received a CIS report related to an allegation of staff to resident physical abuse, related to a resident. Upon the home's investigation, it was determined that a PSW was using a mechanical lift without a second staff member present for the resident. The home's Mechanical Lifts policy indicates that two trained staff are required at all times when performing a mechanical lift. The resident's care plan indicates they require a mechanical lift and two staff members present during a transfer. The PSW stated they used a mechanical lift without a second staff member present and confirmed that they needed a second staff member present to perform a transfer for the resident. As a result, the staff member who used the mechanical lift with the resident by themselves posed a risk of injury to the resident.

Sources: The resident's care plan; Mechanical Lifts policy (dated August 2017); the home's investigation notes; interviews with a PSW and other staff. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: 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 failed to ensure that the medications are stored in a medication cart for two residents.

An observation was conducted for a resident's room and found medications in an unlocked location. The ADOC stated that the medications found should not have been placed in the resident's room.

Sources: Observation in a resident's room; the resident's plan of care; Interviews with ADOC and other staff. [s. 129. (1) (a)]

2. An observation was conducted for another resident's room and found a medication in unlocked locations. The RPN confirmed that this resident should not have had this medication in their room and removed them afterwards.

Sources: Observation in the resident's room; the resident's plan of care; Interviews with the RPN and other staff. [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, (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 (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, to be implemented voluntarily.

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. (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 failed to ensure that a medication incident report was completed for a resident related to the medications that were not taken.

A review of the resident’s charts did not indicate whether a medication incident report was completed related to the incident where the RPN found the resident not taking their prescribed medications. The RPN indicated that they did not complete a medication incident report when they first discovered the resident's medications in their room. As a result, there was a risk to the resident with not taking these medications properly.

Sources: The resident’s plan of care, progress notes; interviews with an RPN and other staff. [s. 135. (1)]

Issued on this 5th day of October, 2020

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

Original report signed by the inspector.