

**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**

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de
Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
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Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 2021	2021_882760_0014	005084-21	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): May 5, 6, 7, 2021.

The following intakes were completed in this critical incident inspection:

A log was related to a medication incident.

During the course of the inspection, the inspector(s) spoke with Pharmacists, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Associate Directors of Care (ADOC), and the Director of Care (DOC).

During the course of the inspection, the inspectors observed care activities on the units, reviewed relevant policies and procedures and reviewed resident records.

Inspector #653 was also present during this inspection.

**The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication**

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

4 WN(s)

3 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that two residents received their medication, in accordance to the prescriber's instructions.

A review of the progress notes indicated that a resident had symptoms and was sent to the hospital, where they were diagnosed with a medical condition. When the resident returned to the home, a medication order was given. According to the home's investigation, the resident was supposed to be on this medication, prior to their medical incident, but was not receiving it for a duration of time. A pharmacist had indicated that for a period of time, this medication was not being sent from the pharmacy to the home. The DOC indicated that this discrepancy could have been caught earlier by the registered staff. The DOC added that there was a potential negative impact to the resident when they did not receive their medication for a period of time.

Sources: The home's investigation notes; a resident's progress notes and medical chart; Interviews with a pharmacist, the DOC and other staff. [s. 131. (2)]

2. A review of the home's medication incident report indicated that a student RPN had administered a resident's medications at a different time from the directions by the prescriber. An RPN stated that as a result of this error, the resident had received an incorrect dosage of one of their medications. The DOC confirmed that the RPN did not ensure the student followed the prescriber's instructions related to this resident's medications.

Sources: The medication incident report related to a resident; Interviews with an RPN, the DOC and other staff. [s. 131. (2)]

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe environment related to infection prevention and control measures specified in Directive #3, regarding wearing the required eye protection.

The Chief Medical Officer of Health (CMOH) implemented Directive #3, which has been issued to Long-Term Care Homes (LTCHs), and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak in LTCHs. As part of this directive, dated May 4, 2021, all staff and essential visitors are required to wear appropriate eye protection when they are within 2 metres of a resident as part of provision of direct care and/or when they interact with a resident in an indoor area.

Observations were made throughout the home and noted the following:

- Two visitors were seen sitting next to the residents without wearing their face shield.
- A caregiver for the resident was seen sitting in the hallway of a resident unit without wearing their face shield.

The ADOC stated that when visitors and caregivers are inside resident rooms and hallways, the home expects them to wear their face shield, along with their surgical mask.

There was potential risk to the resident, as the failure to wear the eye protection may risk transmission of infectious agents.

Sources: Review of Directive #3, dated May 4, 2021; Observations made throughout the home; Interviews with visitors, the ADOC and other staff. [s. 5.]

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 home is a safe and secure environment for its residents, 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 failed to ensure that their Medication Management policy included in the required medication program was complied with, for two residents.

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 titled, "The Medication Pass". The policy states that after the nurse administers a resident's narcotic medication, they are to document this in the appropriate monitoring count form in addition to the Medication Administration Record (MAR).

An observation was conducted and an RPN had finished administering a narcotic medication but did not sign the individual count sheet until prompted by the inspector.

A further review of the narcotic count sheet was made after comparing each resident's narcotic medication on a resident unit. A resident's narcotic medication did not align with what was documented in the individual count sheet verses the number of narcotic medications inside their respective package.

The DOC confirmed that the registered staff should be signing the resident's narcotic count sheet right after they administer the medication to the resident. There was minimal risk to residents, as the failure to properly document the narcotic medication count may lead to further discrepancies, including up to potential medication incidents.

Sources: The home's policy on the medication pass, dated March 2021; Observation on a resident unit; Review of the count sheet binder and narcotic medications on a resident unit; Interviews with an RPN, the DOC 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, (b) is complied with, 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 an RN completed a medication incident report and informed the physician, the DOC and the resident's substitute decision maker (SDM) after discovering a medication incident.

The home's investigation notes indicated that a resident did not receive a medication prescribed to them for a period of time. A further review indicated that an RN had informed the pharmacy during the period that the resident was not receiving this medication. The RN stated they did not complete a medication incident form nor inform the doctor, the resident's SDM or the home's DOC. The DOC stated that the RN should have taken these measures to follow up with this resident's medication. There was potential risk of harm to the resident, as the failure to report this medication omission as a medication incident and conducting a follow up with the appropriate staff members caused a delay in the discovery of this incident.

Sources: The home's investigation notes; A resident's medical chart; Interviews with an RN, the DOC and other staff. [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 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 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, to be implemented voluntarily.

Issued on this 1st day of June, 2021

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) /

Nom de l'inspecteur (No) : JACK SHI (760)

Inspection No. /

No de l'inspection : 2021_882760_0014

Log No. /

No de registre : 005084-21

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : May 27, 2021

Licensee /

Titulaire de permis : Extendicare (Canada) Inc.
3000 Steeles Avenue East, Suite 103, Markham, ON,
L3R-4T9

LTC Home /

Foyer de SLD : Extendicare Rouge Valley
551 Conlins Road, Toronto, ON, M1B-5S1

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Jessica Laurie

To Extendicare (Canada) Inc., you are hereby required to comply with the following
order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # /

No d'ordre : 001

Order Type /

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Order / Ordre :

The licensee must be compliant with s. 131 (2) of the O. Reg. 79/10.

Specifically, the licensee must:

1. Ensure two residents receive their medications in accordance with the directions for use specified by the prescriber.
2. Ensure registered staff adhere to best practice guidelines for medication administration by conducting audits until the compliance due date. The home will determine the frequency of the audits and the person responsible for conducting the audits. A copy of this audit will be made available to the inspector, upon request.

Grounds / Motifs :

1. The licensee failed to ensure that two residents received their medication, in accordance to the prescriber's instructions.

A review of the progress notes indicated that a resident had symptoms and was sent to the hospital, where they were diagnosed with a medical condition. When the resident returned to the home, a medication order was given. According to the home's investigation, the resident was supposed to be on this medication, prior to their medical incident, but was not receiving it for a duration of time. A pharmacist had indicated that for a period of time, this medication was not being sent from the pharmacy to the home. The DOC indicated that this discrepancy could have been caught earlier by the registered staff. The DOC added that there was a potential negative impact to the resident when they did not receive their medication for a period of time.

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

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

Sources: The home's investigation notes; a resident's progress notes and medical chart; Interviews with a pharmacist, the DOC and other staff. (760)

2. A review of the home's medication incident report indicated that a student RPN had administered a resident's medications at a different time from the directions by the prescriber. An RPN stated that as a result of this error, the resident had received an incorrect dosage of one of their medications. The DOC confirmed that the RPN did not ensure the student followed the prescriber's instructions related to this resident's medications.

Sources: The medication incident report related to a resident; Interviews with an RPN, the DOC and other staff.

Severity: There was potential risk of harm to both residents. The risk of not following the prescriber's directions for medication usage may result in negative outcomes in the resident's medical condition.

Scope: The scope of this non-compliance was a pattern because there were two residents identified who did not receive their medications in accordance to the prescriber's instructions, out of a total of three residents reviewed.

Compliance History: In the last 36 months, multiple WNs and VPCs were issued to the home related to different sub-sections of the legislation. (760)

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

Aug 27, 2021

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

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 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:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

**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 des Soins de longue durée
1075, rue Bay, 11^e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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

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)
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière
d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 27th day of May, 2021

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Jack Shi

Service Area Office /

Bureau régional de services : Central East Service Area Office