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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 8, 2013	2013_230134_0020	O-000919-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE STARWOOD
114 STARWOOD ROAD, NEPEAN, ON, K2G-3N5

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

COLETTE ASSELIN (134)

Inspection Summary/Résumé de l'inspection

Ontario

Ministry of Health and Long-Term Care

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The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 30, November 1 and 5, 2013

During the course of the inspection, the inspector(s) spoke with the Home's Administrator, Assistant Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN)and Personal Support Worker (PSW)

During the course of the inspection, the inspector(s) reviewed the Health Records, CCAC's admission chart and Medication Administration Records of Resident #1, the Medical Pharmacies MedsCheck Review form, the laboratory results and the Licensee's Chemical Restraint Policy # 08-10-03 and the Common Law Duty Policy #RES-08-10-4.

The following Inspection Protocols were used during this inspection:
Pain

Personal Support Services

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to comply with the O. Reg. 79/10 s.134 (a) and (b), in that Resident #1's response, to taking a combination of drugs including psychotropic drugs, was not monitored or documented as appropriate to the risk level of the drugs, and appropriate actions were not taken in response to the adverse reactions to the combination of drugs including psychotropic drugs.

Staff member #S100 was interviewed and had indicated he/she was on duty the day Resident #1 was admitted to the home. He/she reported that on the day of the resident's admission, Resident #1 walked in with a walker, smiled, was pleasant, was confused but had eye contact and recognized his/her family members. Staff member #S100 indicated the resident was able to feed self and complete a meal with minimal assistance. He/she also reported that the PSW assigned to the resident had reported that no resistance or aggression was noted during the care.

Based on the progress notes Resident #1 was exhibiting responsive behaviours during an identified period in August, 2013. There are entries indicating Resident #1 was aggressive on 5 different occasions during that period. There is an entry in the progress notes of an identified date in August, 2013 indicating Resident #1 was agitated and aggressive to staff during supper time. There is an entry indicating a note was left for the medical doctor to leave a medication order for agitation and aggression as needed.

On a specified date in August, 2013 psychotropic medication was ordered twice a day via a telephone order. As per the Medication Administration Records, the medication was administered at 17:00 on a specified date in August and was given on a regular basis three more times until it was discontinued by the attending physician at 13:00. There is no documentation in the progress notes to indicate the effect of the medication administered and there is no documentation regarding the reason why it was discontinued. There is an entry in the progress notes of a specified date in August indicating "the physician spoke with the resident's SDM in regards to the resident's behaviours and the new orders for antipsychotics". After explanation the SDM appeared to understand the situation". On a specified date in August, 2013 there is an entry that the resident's SDM reported to the nurse that the resident had very poor appetite at lunch and had been fed breakfast by the RPN.

Staff member #S100 was interviewed on October 30, 2013 and reported to the inspector that after the psychotropic medication was given, Resident #1's SDM had

reported that the resident looked as though he/she was having difficulty swallowing. There is no clear documentation of that information in the progress notes.

A different psychotropic medication was ordered on a specified date in August and administered once, before the dosage was changed and then was administered four other times as ordered. The progress notes were reviewed and there is an indication that the resident was refusing the medication. It is not clear why the psychotropic medication was changed. Furthermore, there are no chart entries to indicate the resident's response and the effectiveness of the new psychotropic medication administered.

On a specified date in August there is a chart entry indicating the resident was extremely physically aggressive with staff administering his/her medication). On the same date there is a chart entry indicating Resident #1 became physically abusive shouting and trying to hit everyone within reach. A different psychotropic medication was then administered as per medical order. An order for a consult with the Royal Ottawa Hospital's Psychogeriatric team, had also been given. No further documentation was done regarding the resident's response to the medication until a family member reported on a specified date in August that the resident hardly ate anything and refused to take his/her medications.

The Licensee's Policy on Chemical Restraints #08-10-03, was reviewed. There is an entry under bullet #2 (f) that specifies the following: "Observe resident for any side effects from the medication on each shift for the next 72 hours; ensure documentation is completed in progress notes to demonstrate what was done"; under bullet 2 (g), "communicate any side effects to the physician for further review and actions if needed". There is another entry under bullet #5 that specifies "the registered nurses are to ensure the resident's response to the administration of the medication and note any observed side effects of the medication". Under Bullet 6 a list of side effects to anti-psychotic medications is provided and if observed, the registered staff are to contact the physician for further direction.

The progress notes were reviewed for a specified period in August, 2013 and there is no clear documentation as it relates to the 72-hour post psychotropic medication monitoring. There is no documentation linking the many symptoms exhibited by the resident as of a specified date in August, to the administration of the combination of medication including psychotropic medications.

2. The Medical Pharmacies' MedsCheck Review form, was reviewed by the inspector. There is an indication that the pharmacist had discussed his/her observations with the Health Care team related to post psychotropic medication administration. Suggestions were made by the pharmacist to discontinue certain medications and change others. The telephone order to discontinue 4 medications was received three days after the pharmacist's consult.

There are several entries in the progress notes indicating Resident #1's condition was changing for several days in August. Blood work was done on a specified day in August, 2013. The blood work results received by fax were reviewed and revealed a higher than normal sodium level.

The Daily Flow sheets were reviewed. It is to be noted that there are several entries indicating the resident had not voided on several shifts.

On specified day in August, 2013 Resident #1 vomited at 15:00. The pulse was much higher than his/her baseline pulse at admission. It was not monitored again until before the resident left for the hospital. There are no entries in the progress notes to indicate the physician was contacted for further direction. Vital signs were not monitored regularly during the resident's declining condition.

There is a nursing chart entry documenting "discussed sending the resident out to hospital for further investigation several times with family however they have stated they would like to wait till after the assessment from the Royal Ottawa Hospital to make a decision". There is a second entry on the same day in September indicating the resident was transferred to hospital as per the family's request.

The resident's condition had continued to decline and the resident was transferred to hospital as a result of the possible adverse effects of the psychotropic medications administered.

As such, the licensee failed to take appropriate action in response to the adverse drug reaction and combination of drugs administered to Resident #1. [s. 134. (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 19th day of November, 2013

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

Colette Asselin

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	COLETTE ASSELIN (134)
Inspection No. / No de l'inspection :	2013_230134_0020
Log No. / Registre no:	O-000919-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 8, 2013
Licensee / Titulaire de permis :	EXTENDICARE NORTHEASTERN ONTARIO INC 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE STARWOOD 114 STARWOOD ROAD, NEPEAN, ON, K2G-3N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	SUE MACGREGOR

To EXTENDICARE NORTHEASTERN ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 134. Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with section 134 (a) and (b), to ensure that newly admitted residents exhibiting responsive behaviours and who are administered a combination of drugs, including psychotropic drugs are:
1. Monitored for their response and the effectiveness of the medication. 2. Ensure that appropriate actions are taken in response to any adverse reaction to a combination of drugs, including psychotropic drugs. 3. In particular this plan shall include registered nursing staff training to ensure the "Chemical Restraint Policy and Procedure" is followed with particular attention to the SDM's consent, documentation and when to contact the physician for further directions.

The plan must be submitted in writing to Inspector Colette Asselin at 347 Preston Street, 4th floor, Ottawa ON K1S 3J4 or by fax at 613 569-9670 on or before November 19, 2013

Grounds / Motifs :

1. 1. The licensee has failed to comply with the O. Reg. 79/10 s.134 (a) and (b), in that Resident #1's response, to taking a combination of drugs including psychotropic drugs, was not monitored or documented as appropriate to the risk

level of the drugs, and appropriate actions were not taken in response to the adverse reactions to the combination of drugs including psychotropic drugs.

Staff member #S100 was interviewed and had indicated he/she was on duty the day Resident #1 was admitted to the home. He/she reported that on the day of the resident's admission, Resident #1 walked in with a walker, smiled, was pleasant, was confused but had eye contact and recognized his/her family members. Staff member #S100 indicated the resident was able to feed self and complete a meal with minimal assistance. He/she also reported that the PSW assigned to the resident had reported that no resistance or aggression was noted during the care.

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The Licensee's Policy on Chemical Restraints #08-10-03, was reviewed. There is an entry under bullet #2 (f) that specifies the following: "Observe resident for any side effects from the medication on each shift for the next 72 hours; ensure documentation is completed in progress notes to demonstrate what was done"; under bullet 2 (g), "communicate any side effects to the physician for further review and actions if needed". There is another entry under bullet #5 that specifies "the registered nurses are to ensure the resident's response to the administration of the medication and note any observed side effects of the medication". Under Bullet 6 a list of side effects to anti-psychotic medications is provided and if observed, the registered staff are to contact the physician for further direction.

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The resident's condition had continued to decline and the resident was transferred to hospital as a result of the possible adverse effects of the psychotropic medications administered.

As such, the licensee failed to take appropriate action in response to the adverse drug reaction and combination of drugs administered to Resident #1. [s. 134. (b)]

The risk level associated with not monitoring a resident's response and not documenting the effectiveness to a combination of drugs, including psychotropic

drugs, is deemed to be a high risk for harm and provided sufficient grounds to issue an order. (134)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2013

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 8th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Colette Asselin

Name of Inspector / Nom de l'inspecteur : COLETTE ASSELIN

Service Area Office / Bureau régional de services : Ottawa Service Area Office