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 26, 2021	2021_901759_0008	010653-21, 012538-21, 015517-21, 015761-21	Complaint

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 York
333 York Street Sudbury ON P3E 5J3

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

KEARA CRONIN (759), LOVIRIZA CALUZA (687)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 4-8, and 12-15, 2021.

The following intakes were inspected upon during this Complaint Inspection:

- One intake related to concerns regarding a resident's care;
- One intake related to concerns with medication administration, diets, equipment availability, falls management and bathing;
- One intake related to concerns with short staffing, care concerns, neglect and general building maintenance; and
- One intake related to concerns regarding a resident's care.

A Critical Incident Systems Inspection #2021_901759_0009 and Follow-Up Inspection #2021_901759_0010 were conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Cares (ADOC), Physicians, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Activity Aides, Dietary Manager, Dietary Supervisor, Office Manager, DOC Clerk, Support Services Manager, Dietary Aides, Laundry services, Housekeepers, families, and residents.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed infection prevention and control (IPAC) practices, reviewed relevant health care records, reviewed the home's internal investigation notes, and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

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. 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 has failed to ensure that an RPN complied with the medication pass policy included in the required medication management system program.

Section 114 (3) of the Ontario Regulation 79/10 required the licensee to ensure that the written policies and protocols of the medication management system were implemented and if there were none, in accordance with prevailing practices.

Specifically, the RPN did not comply with the licensee’s policy titled "The Medication Pass", last revised January 2018, which indicated that registered staff were to document each medication administered or document if a medication was not given.

The Inspector reviewed a resident’s Electronic Medication Administration Record (EMAR) and identified that an administered medication was not documented.

The Assistant Director of Care (ADOC)/Medication Lead acknowledged that the RPN had not documented on the residents’ EMAR as per the home’s policy.

Sources: Complaint submitted to the Director; observations of staff and residents; health care record reviews; review of the home’s policy “The Medication Pass”, last revised January 2018; interviews with an RPN and other staff members. [s. 8. (1) (b)] [s. 8. (1)]

2. The licensee has failed to ensure that registered staff complied with the homes ordering medications policy that was included in the required medication management system program.

Specifically, registered staff did not comply with the licensee’s policy titled "Ordering

Medications", last revised February 2019, which indicated that when processing prescriber's orders a nurse was to sign and date on the prescriber's order after the transmission of order to pharmacy was verified, and ensure the Medication Administration Record (MAR) was checked with the original prescriber's order. In addition the nurse was required to leave charts with new orders flagged until a second nurse check was completed when receiving the medication.

A resident received a medication order for the treatment of a health condition.

The order was not processed properly and there was a delay in the resident receiving the medication.

Sources: the home's policy "Ordering Medications", last revised February 2017; interviews with the DOC and other relevant staff members; a Medication Incident - Final Report; and a resident's health care records. [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 that where the Act or 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident received bloodwork as ordered by the physician.

This finding is further evidence to support Compliance Order (CO) #001 that was issued during inspection #2021_864627_0017 pursuant to LTCHA, s. 6(7). with a compliance due date of September 3, 2021.

The resident had an order for bloodwork to be drawn. Upon review of their bloodwork results, it was identified that the bloodwork was not drawn as ordered.

The Office Manager indicated that the bloodwork did not get done as ordered.

Sources: interviews with the DOC, Office Manager and other relevant staff; and a resident's progress notes, physical chart, lab results, and physician orders. [s. 6. (7)]

Issued on this 27th day of October, 2021

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

Original report signed by the inspector.