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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de 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
Jun 17, 2019	2019_664602_0027	002576-18, 008461-18, 011559-18, 012789-18, 015928-18, 019269-18, 026361-18, 028654-18, 030154-18, 031520-18	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 Port Hope
360 Croft Street PORT HOPE ON L1A 4K8

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

WENDY BROWN (602), SUSAN DONNAN (531)

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 21 - 24, May 27 - 31 and June 3 - 7, 2019

Log #030154-18/ CIS #2925-000033-18 – regarding alleged resident to resident emotional abuse.
Log #002576-18/ CIS #2925-000006-18 – regarding a fall with injury and transfer to hospital.
Log #008461-18/ CIS #2925-000011-18 – regarding a fall with injury and transfer to hospital.
Log #011559-18/ CIS #2925-000015-18 – regarding a fall with injury and transfer to hospital.
Log #000023-18/ CIS #2925-000023-18 – regarding incorrect dosage of medication.
Log #028654-18/ CIS #2925-000030-18 – regarding a fall with injury and transfer to hospital.
Log #012789-18/ CIS #2925-000017-18 – regarding alleged staff to resident neglect.
Log #026361-18/ CIS #2925-000026-18 – regarding a fall with injury and transfer to hospital.
Log #015928-18/ CIS #2925-000019-18 – regarding resident to resident physical abuse.
Log #031520-18/ CIS #2925-000035-18 – regarding alleged staff to resident neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), a physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the physiotherapist, residents and family members.

In addition, observations of resident care service delivery, and reviews of electronic health care records, meeting minutes, investigation files, laboratory results, hospital reports/documents and relevant policies/procedures were completed.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

- **5 WN(s)**
- **4 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 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 following finding is related to Log #031520-18/CIS #2925-000035-18.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

On a specified date, resident #012 was found sitting alone, on the toilet, by Registered Practical Nurse (RPN) #136 at a specified time. The RPN immediately offered support to the resident who was transferred off of the toilet, provided care and assisted to bed. A head to toe assessment was completed; redness to the resident's bottom from the toilet seat was noted, however, there were no visible areas of skin breakdown. The resident denied pain and showed no signs of distress following the incident.

Resident #012's plan of care outlined the following specific to transfers and toileting:
TRANSFERS: Partial weight bearing status
GOAL: Resident will transfer safely with two person extensive assistance by the review date.
INTERVENTIONS: Extensive assistance: sit to stand lift: two staff to manoeuvre lift.
Offer reassurance to resident throughout transfers.

TOILET USE: Extensive assist.
GOAL: Resident will use the toilet safety throughout next review date.
INTERVENTIONS: Extensive assistance of two staff required for transfer to and from the toilet.

Interviews with Director of Care (DOC) #101 and multiple PSW staff, indicated that safe resident care and education specific to toileting outline that residents are "never to be left on the toilet unattended unless this is specifically outlined in the resident's care plan". Frequent reminders regarding this direction have been provided in staff meetings and in-services that highlight plan of care safety and/or possible incidents that could occur if/when residents are left unattended on the toilet e.g. falls, fractures, head injuries etc.

The licensee failed to ensure that the toileting care set out in the plan of care was provided to resident #012 as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 following finding is related to log #012789-18/ CIS #2925-000017-18

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 48, the licensee was required to ensure that a falls prevention and management program that reduces the incidence of falls and the risk of injury was developed and implemented in the home: Specifically, staff did not comply with the "Resident Care - Fall Prevention and Management Program Policy, RC 15-01-01 (revised February 2017)

On a specified date, Personal Support Worker (PSW) #107 found resident # 011 at a specified time, laying on their side on the floor. The resident indicated they had fallen and that they were in pain. Registered Nurse (RN) #109 was alerted to the fall

immediately by PSW #107, however, the RN proceeded to dispense and administer medication to several other residents prior to attending to resident #011. Investigation documentation indicated that emergency services (EMS) left with resident #011 a specified period of time later.

The Resident Care Fall Prevention and Management Program Policy, RC 15-01-01, indicates in post fall management procedure item 1. c. that staff are to "treat any injuries and manage pain". Investigation notes outline that resident #011 "was in significant pain [and] required hospital transfer" for surgery. Documentation further notes that "approximately 50 minutes elapsed" between the time of the PSW's initial alert of the RN to the fall and "the time that EMS were called".

The licensee failed to ensure RN #109 complied the "Resident Care - Fall Prevention and Management Program Policy", specifically as it relates to response to falls and the treatment of injury and/or pain. [s. 8. (1) (a),s. 8. (1) (b)]

2. The following finding is related to log # 019269-18 / CIS 2925-000023-18.

The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, that the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (1), the licensee was required to ensure that a medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents was in place. Specifically, staff did not comply with the licensee's High Alert Medications Policy RC-16-01- 08 (revised February 2017) which is part of the licensee's Resident Care Manual / Medication Management System

On a specified date at a specified time, Registered Nurse (RN) #122 received a report indicating that resident #016's blood sugar was high. RN #122 contacted the physician who ordered a rapid acting insulin, "stat". As there were no insulin syringes available for "stat" administration of the insulin, RN#122 directed Registered Practical Nurse (RPN) #121 to use a TB syringe. The rapid acting insulin was given to the resident by RPN #121, however, administration was neither observed by RN #122 who received a call during this time; nor was the syringe checked by RN #122 at the point of care. The RN recognized there may have been an error when RPN #121 commented that it took longer to administer the injection than they had anticipated. On inquiry, RN#122 realized that

resident #016 had received the wrong dose of insulin.

The licensee's "High Alert Medications" policy RC 16-01-08 (revised February 2017), indicates that "staff will complete an independent double check" when "two nurses are available in the home". An "independent double check is a process in which a second practitioner conducts a verification at the point of care prior to administering insulin".

The resident was transferred to hospital where they were assessed and treated for low blood sugar. Resident #016 returned to the home the following day.

RN #122 failed to follow the licensee's "High Alert Medications" policy RC 16-01-08. [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 policy, the licensee is required to ensure that the policy, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with., to be implemented voluntarily.

WN #3: 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 following finding is related to Log #031520-18/CIS #2925-000035-18.

The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

On a specified date at a specified time, resident #012 was found sitting alone, on their toilet, by Registered Practical Nurse (RPN) #136. An investigation into the length of time and the circumstances surrounding the incident revealed resident #012 was left on the toilet unattended for a specified period of time. Resident #012 was transferred to the toilet by PSW #133 and #134 at a specified time on a specified shift; prior to completing the resident's transfer off of the toilet PSW staff #133 and #134 "left the resident unattended and continued [to provide] care to other residents". Both PSWs indicated they had failed to remember to complete "resident [#012's transfer] off the toilet" before they left at the end of their shift despite their awareness of safe resident handling and regular education specific to transfers/assisting residents.

Assessment by the next shift's staff following discovery of resident #012 found that the resident was confused and unable to call for assistance. In addition, redness to the resident's buttocks from the toilet was noted, but resolved following care.

The licensee failed to ensure that staff used safe transferring techniques when they left resident #012 alone on the toilet. [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 safe transferring and positioning devices or techniques are used when assisting residents, to be implemented voluntarily.

WN #4: 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 following finding is related to log # 019269-18 / CIS 2925-000023-18.

The licensee failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On July 24, 2018 at 2100 hours Registered Nurse (RN) #122 received a report indicating that resident # 016's blood sugar (BS) was high. RN #122 contacted the physician who ordered a rapid acting, insulin "stat". As there were no insulin syringes available for "stat" administration of the rapid acting insulin, RN#122 directed Registered Practical Nurse (RPN) #121 to use a TB syringe. RN #122 was alerted to a possible medication error when RPN #121 commented that the injection took longer than they had anticipated. On inquiry, RN#122 realized that the resident received too much insulin. The physician was alerted; and the decision was made to send the resident to hospital for monitoring and treatment if / as necessary.

The resident returned from hospital on a specified date after intravenous treatment.

In an effort to prevent reoccurrence all insulin syringes in the home were replaced by insulin pens.

The licensee failed to ensure that medications were given to residents #016 in accordance with directions for use specified by the prescriber [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The following finding is related to Log # 012789-18/ CIS # 2925-000017-18:

The licensee failed to ensure that the Director was immediately informed regarding improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

On a specified date, Personal Support Worker (PSW) #107 found resident #011 on the floor; the resident advised that they had fallen, and indicated they were in pain.

Critical Incident (CI) report #2925-000017-18 indicated that PSW #107 voiced their concern regarding RN# 109 "not responding to a reported fall in a timely manner" to DOC #108 on a specified date. The PSW stated that the "RN proceeded to dispense and administer medication to co-residents after being informed of a fall". The report further notes that when PSW #107 asked the RN if they were going to come assess the resident, the RN responded "I am not going to back track". The PSW stated they "believed the RN completed [their] medication pass before calling EMS to transfer the resident to the hospital" for assessment/treatment. DOC #101 indicated in an interview with inspector #602, that DOC #108 reminded the PSW that concerns regarding improper care/possible neglect must be reported immediately. The CI report indicated the incident was reported to the Director on two days after the incident occurred.

Investigation documentation outlines that the resident was in "significant pain and required a hospital transfer".

The Director was not immediately informed of the improper care of resident #011 following their fall. [s. 24. (1)]

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Issued on this 18th day of June, 2019

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

Original report signed by the inspector.