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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
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Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
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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
Apr 27, 2022	2022_946111_0006	018004-21, 020293-21	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 Oshawa
82 Park Road North Oshawa ON L1J 4L1

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

LYNDA BROWN (111)

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): February 22 to 25, 28, March 1 to 4, 2022.

There was a compliant related to medication incidents, insufficient staffing and two Critical Incidents (CI) related to missing and /or unaccounted control substances inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Acting Director of care (Acting DOC) and Assistant Director of Care (ADOC).

During the course of the inspection, the inspector reviewed: health records of residents, medication incidents and the home's policy on medication incidents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 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. 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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

Two RPNs discovered a resident was missing their narcotic analgesic during the end of shift count. There was no documentation to indicate the resident had received the drug and the resident was unable to attest that they had received the drug. The ADOC indicated the RPNs failed to report the missing narcotic immediately, did not complete a medication incident report regarding the incident, did not report the incident to the physician, Medical Director, pharmacy or the resident's SDM or notified the police. The ADOC indicated both RPNs involved in the missing narcotic no longer worked in the home and the DOC working at the time of the incident no longer worked in the home. Failing to ensure that the medication incident for a resident was documented, the

resident was assessed and the incident reported as required, may result in additional medication incidents of missing narcotics.

Sources: CI, health record of a resident and interview of staff.

2. The licensee has failed to ensure that a medication incident involving a number of residents was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

A complaint was received by the Director regarding a number of residents in a specified area not receiving their medications. The ADOC indicated the DOC that was working at the time of the incident no longer worked in the home and confirmed that on an identified date and time, residents in a specified area had not received medications as prescribed due to insufficient registered staffing. The ADOC confirmed a medication incident report was completed for the incident. The medication incident report identified a number of residents that had not received their medications as prescribed and only the pharmacy had been notified. The Inspector determined after review of the health records of all the residents in a specified area indicated there were a higher number of residents than was identified on the medication incident report who had not received their medications as prescribed, some of which included high risk medications. There was no documented evidence any of the residents involved were assessed and actions taken, the resident's and/or their SDMs, the Medical Director , the physician who prescribed the drug had been notified of the medications incidents that had occurred. The pharmacy was not aware that there was actually a greater number of residents involved. Failing to ensure that all medication incidents involving residents were assessed, documented and reported as required, may lead to negative outcomes not being identified and a recurrence.

Sources: health records for a number of residents, medication incident report and interview of staff.

3. The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

An agency RPN discovered that a resident was missing their narcotic analgesic and reported the missing narcotic to an RN a number of hours later. There was no documented evidence a medication incident report was completed for the incident. There was no indication that the resident was assessed for pain, or to indicate the SDM, pharmacy, physician, the Medical Director, or the police were notified. The ADOC provided documented evidence to indicate the family, physician and the police were informed of the medication incident a number of days later. The ADOC indicated the corrective action they took to prevent a recurrence included requesting the physician change the residents medication due to a number of incidents of their narcotic analgesic missing and confirmed the request to the physician occurred as a result of the inspection, a number of months after the incident occurred.

Sources: CI, a resident''s health record, medication incident investigation and interview of staff.

4. The licensee has failed to ensure that all medication incidents were documented, reviewed and analyzed and corrective action taken as necessary, with a written record kept.

There were three separate medication incidents that had occurred, one involving a number of residents not receiving their medications as prescribed on a specified date and time, including high risk medications, and two others involving two separate residents on separate dates, both having missing or unaccounted for narcotics. The ADOC confirmed they had no documented record to demonstrate all three medication incidents, had been reviewed and analyzed with corrective actions taken to prevent a recurrence. Failing to ensure that medication incidents are reviewed and analyzed, may lead to further medication incidents occurring with no corrective actions taken and may lead to serious negative outcomes for residents.

Sources: two CIs, resident health records, medication incident investigations and interview of staff.

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 :

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Observations on two separate dates, in a number of common areas, by the Inspector, indicated that there were a number of residents congregated within close proximity (less than 1 foot apart) and not wearing any masks. The IPAC lead also witnessed the same. Registered staff who were present made no attempt to ensure residents were physically distanced as required and/or wearing a mask, where able. Directive #3 at that time included that homes were to ensure that physical distancing (a minimum of 2 metres or 6 feet) was practised by all individuals at all times, except for the purposes of providing direct care to a resident(s). Failing to ensure that residents were physically distanced or wearing masks, may lead to additional transmission of infection.

Sources: observations, Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, Date of Issuance: December 17, 2021, and interview with the staff.

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 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. 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 :

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

An anonymous complaint was received by the Director regarding residents in a specified area that had not receiving their medications as prescribed. The ADOC confirmed that they became aware the day after the incident occurred that a number of residents in a specified area, on an identified shift, had not received their medications as prescribed due to insufficient registered staff. The medication incident report did not identify all of the residents that had not received their medications as prescribed and the health records of the residents in the specified area identified additional residents who had not received their medications as prescribed, some of which included high risk medications. Failing to provide residents with their prescribed medications can lead to serious negative outcomes for the residents.

Sources: health records of a number of residents, medication incident report, staff schedules and interview of staff.

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.

Issued on this 29th day of April, 2022

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2022_946111_0006
Log No. / No de registre :	018004-21, 020293-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 27, 2022
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, Markham, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Oshawa 82 Park Road North, Oshawa, ON, L1J-4L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Christa Griffiths

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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. 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

(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).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s. 135(1).

Specifically, the licensee shall ensure:

All registered staff, including agency registered staff are retrained on the home's policy of medication incidents to ensure they are aware of their roles and responsibilities, specifically, that any medication incidents involving a resident are to be documented, including actions to assess and maintain the residents health; and notify the resident (where possible), residents Substitute Decision Maker (SDM),the DOC, Medical Director, the physician who prescribed the drug, and the pharmacy of any medication incidents involving a resident. And if the medication incident involves a missing or unaccounted for narcotic or controlled substance, the police are to be immediately notified. A documented record is to be kept of the training and provided to the Inspector upon request.

Grounds / Motifs :

1. The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the

resident's SDM, 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.

Two RPNs discovered a resident was missing their narcotic analgesic during the end of shift count. There was no documentation to indicate the resident had received the drug and the resident was unable to attest that they had received the drug. The ADOC indicated the RPNs failed to report the missing narcotic immediately, did not complete a medication incident report regarding the incident, did not report the incident to the physician, Medical Director, pharmacy or the resident's SDM or notified the police. The ADOC indicated both RPNs involved in the missing narcotic no longer worked in the home and the DOC working at the time of the incident no longer worked in the home. Failing to ensure that the medication incident for a resident was documented, the resident was assessed and the incident reported as required, may result in additional medication incidents of missing narcotics.

Sources: CI, health record of a resident and interview of staff. (111)

2. 2. The licensee has failed to ensure that a medication incident involving a number of residents was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

A complaint was received by the Director regarding a number of residents in a specified area not receiving their medications. The ADOC indicated the DOC that was working at the time of the incident no longer worked in the home and confirmed that on an identified date and time, residents in a specified area had not received medications as prescribed due to insufficient registered staffing. The ADOC confirmed a medication incident report was completed for the incident. The medication incident report identified a number of residents that had not received their medications as prescribed and only the pharmacy had been notified. The Inspector determined after review of the health records of all the

residents in a specified area indicated there were a higher number of residents than was identified on the medication incident report who had not received their medications as prescribed, some of which included high risk medications. There was no documented evidence any of the residents involved were assessed and actions taken, the resident's and/or their SDMs, the Medical Director , the physician who prescribed the drug had been notified of the medications incidents that had occurred. The pharmacy was not aware that there was actually a greater number of residents involved. Failing to ensure that all medication incidents involving residents were assessed, documented and reported as required, may lead to negative outcomes not being identified and a recurrence.

Sources: health records for a number of residents, medication incident report and interview of staff. (111)

3. 3. The licensee has failed to ensure that a medication incident involving a resident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, 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.

An agency RPN discovered that a resident was missing their narcotic analgesic and reported the missing narcotic to an RN a number of hours later. There was no documented evidence a medication incident report was completed for the incident. There was no indication that the resident was assessed for pain, or to indicate the SDM, pharmacy, physician, the Medical Director, or the police were notified. The ADOC provided documented evidence to indicate the family, physician and the police were informed of the medication incident a number of days later. The ADOC indicated the corrective action they took to prevent a recurrence included requesting the physician change the residents medication due to a number of incidents of their narcotic analgesic missing and confirmed the request to the physician occurred as a result of the inspection, a number of months after the incident occurred.

Sources: CI, a resident"s health record, medication incident investigation and

interview of staff.

A Compliance Order (CO) was issued with the following taken into consideration:

The severity included a risk of harm to a number of residents who had not received their medications as prescribed on a specified date and times, including high risk medications and they were not documented, assessed or the physician, Medical Director, pharmacy, SDMs or police were notified. In addition, there were two separate medication incidents where residents had their narcotic analgesic missing and were not reassessed for pain or the incidents documented and reported to the physician, Medical Director, pharmacy and SDM.

The scope was widespread as there were three separate medication incidents that had not been documented, one involving a number of residents.

The home's compliance history had previous non-compliance issued to different areas of legislation. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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 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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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 revision 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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 April, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lynda Brown

Service Area Office /
Bureau régional de services : Central East Service Area Office