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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 9, 2017	2016_328571_0033	013464-16	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

PATRICIA MATA (571), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): December 5, 6, 7, 12, 13, 14, 15, 16, 21, 2016.

During this inspection, the following logs were inspected:
Critical Incident Logs #029139-16, #032791-16, #034114-16 re: resident to resident alleged abuse
Critical Incident Log #025100-16 re: staff to resident alleged neglect
Critical Incident Log # 027177-16 re: Medication incident which resulted in resident being transferred to hospital
Follow-up log #007417-16 re: insufficient lighting
Complaint Log #022724-16 re: medication administration

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Social Worker (SW), Behaviour Support Ontario Registered Practical Nurse (BSO RPN), Registered Nurses (RN), Registered Practical Nurses, Personal Support Workers (PSW), Physiotherapist and Nursing Co-ordinator.

In addition, clinical records, administrative records, meeting minutes and policies and procedures were reviewed.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 18.	CO #002	2016_270531_0001	531

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	Legendé 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 the licensee's policy #RC-06-05-07 related to medication administration was complied with to ensure safe, effective administration of medication for resident #050, #051, #002, #053, #054 and #055.

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.

During medication administration observation on a specified date at a specified time, Inspector #194 observed that Registered Practical Nurse (RPN) #125 was administering medication to residents on the unit that should have been given three hours earlier. During an interview, RPN #125 indicated that he/she was administering medication three hours late. The RPN indicated to Inspector #194 during the same interview, that the medication pass was a heavy one. Inspector #194 asked if today was a usual day for medication administration and RPN #125 indicated that there had been a number of phone calls that day that he/she needed to answer.

Review by Inspector #194 of the licensee's medication policy #RC-06-05-07 dated June 2016 titled Medication Management, directs:
-scheduled medications will be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.

Review of the physicians order audit report for day shifts identified:
-on a specified date-13 out of 36 residents were administered their medication outside the one and half hour time frame
-on a separate specified date-22 residents were administered medications late.

The clinical records reviewed by Inspector #194 indicated that resident #050 had specific diagnoses. The physician order audit report for resident #050 on a specified date identified that five medications were given approximately two hours after they were scheduled to be given and three drugs were given approximately two and a quarter hours late. This included three high risk drugs.

A review of the clinical records by Inspector #194 indicated that resident #051 had

several specific diagnoses. The physician order audit report for resident #051 on a specified date identified that seven medications were given approximately two and a half hours after they were scheduled to be given. The second dose of a high risk medication was given only one hour and twenty minutes after the first dose was given. This medication was scheduled to be given four hours apart.

A review of the clinical records by Inspector #194 indicated that resident #002 had several diagnoses. The physician order audit report for resident #002 dated on a specified date identified that 14 medications were given approximately three hours after they were scheduled to be given.
Three medications were administer two and a quarter hours after the first dose given and were actually scheduled to be given four hours apart.

A review of the clinical records by Inspector #194 indicated that resident #052 had several specified diagnoses. The physician order audit report for resident #052 on a specified date identified that nine medications were given over two and a half hours after they were scheduled to be given.

A review of the clinical record by Inspector #194 indicated that resident #054 had several diagnoses. The physician order audit report for resident #054 on a specified date, identified that two medications were given approximately three hours later than originally scheduled.

A review of the clinical record by Inspector #194 indicated that resident #055 had several specified diagnoses. The physician order audit report for resident #055 on a specified date, identified thirteen medications were administered approximately three and a half hours late.

The licensee has failed to ensure that the licensee's policy #RC-06-05-07 related to medication administration was followed to ensure safe, effective administration of medication for residents #050, #051, #002, #053, #054 and #055. [s. 8. (1) (b)] (194)

SEVERITY AND SCOPE STATEMENT FOR THE ORDER:

A compliance order is being issued under LTCHA s.8(1) for not complying with the licensee's medication policy #RC-06-05-07. The scope of the non compliance on the

days identified was wide spread including the entire unit. The potential for injury was high related to a number of high risk medications ordered more than once per shift for resident's identified and were given in close proximity to each other. [s. 8. (1) (b)]

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care that sets out the planned care for resident #005 related to the use of bilateral bed rails.

On December 6, 2016 at 0832 hours, Inspector #624 observed resident #005's bed with two bilateral half rails in the up position.

In an interview on December 12, 2016 with Inspector #624, resident #005 indicated that one identified bed rail prevents the resident from rolling off the bed while the other rail, is used for bed mobility. In separate interviews with PSW #111 on December 12, 2016 and RN #113 on December 13, 2016, both indicated that the resident uses both bed rails for support with ADL's. A review of the resident's current written plan of care does not set out the planned care related to the use of bilateral bed rails by the resident.

In an interview with RN #114 and the DOC by Inspector #624 on December 14, 2016, both staff members indicated that the expectation of the home is that whenever a resident is using bed rails, the bed rails have to be included in the written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

The clinical records indicated in a late entry on a specified date and time by RPN #128, that on the previous evening, resident #046 was being transferred using a specified mechanical lift. During the transfer the resident let go of the lift and slumped in the sling. The morning after the incident, PSW #108 reported to another RPN that resident #046 showed signs of pain. On assessment, the RPN found that the resident sustained a previous specified injury. The resident had been transferred that morning with the same specified lift as the evening before; PSW #108 had not noted the injury until after the transfer. The resident's plan of care was immediately changed to full transfers with a different specified lift. A diagnostic test was ordered that day for the resident. Two days later, a report indicated that the resident had sustained a specified injury.

In an interview on December 16, 2016 with Inspector #571, PSW #108 indicated that he/she worked on a specified day and shift. He/she was not aware of the episode with resident #046 letting go of the specified lift which occurred the day before. Therefore, he/she transferred resident #046 using the same specified lift. After the transfer, PSW #108 noted the resident had sustained a previous injury. PSW #108 informed the RPN of the injury.

Inspector #571 reviewed the "24 Hour Unit Report" completed by the RPN's and the "Nursing Report Form" completed by the RN for the specified day of the incident. No documentation of the incident with resident #046 slumping in the specified lift could be located.

No evidence could be found to indicate RPN #128 reassessed resident #046's ability to use the specified lift after the resident let go of the lift and slumped during the transfer on the specified date. Also, no evidence could be found that RPN #128 revised resident #046's plan of care so that staff working the next day would know to assess resident #046 for his/her ability to be safely transferred with the specified lift before getting the resident out of bed.

The licensee failed to ensure RPN #128 reassessed and reviewed the plan of care for resident #046 after the incident occurring in the specified lift on a specified date. [s. 6. (10) (b)]

3. The licensee failed to ensure that when resident #054 was reassessed and the plan of care was reviewed and revised because the care set out in the plan had not been effective, that different approaches were considered.

Re: Log # 032791-16:

A CIR was submitted to the Director related to an incident occurring on a specified date. The CIR indicated that resident #045 and #041 were involved in an altercation which resulted in an injury to resident #041.

A review of the progress notes by Inspector #571 for a six month period for resident #045 indicated the following:

-on a specified date and time-resident #045 and #041 were involved in a physical altercation. No apparent injury noted to resident #041. Hourly safety checks were put into place
-on a specified date and time-resident #045 and #041 were involved in a physical altercation. A prior intervention was noted to be no longer effective
-on a specified date and time- resident #045 and #041 were involved in a verbal altercation.
-on a specified date and time-a PSW witnessed resident #045 threaten to strike resident #041 No physical contact was made as the PSW was there. Resident #045 requested a

room change as soon as possible.
-on a specified date and time-the nurse was alerted by staff that an altercation was occurring between resident #045 and #041.
-on a specified date and time-resident #045 indicated to Social Worker #102 that resident #041 stares at him/her all the time and he/she feels judged by the resident-resident #045 continued to be on hourly safety checks.
-on a specified date-resident #045 was involved in a physical altercation with resident #041-resident #041 sustained a specified injury
-on a specified date -BSO RPN #103 indicated that resident #045's responsive behaviours had worsened lately for a specified reason
-on a specified date- the Physician indicated that the resident #045's responsive behaviours have been worse lately for a specified reason

During an interview on December 14, 2016 with inspector #571, the Director of Care (DOC) indicated that resident #045's responsive behaviour had worsened for specific reasons. The DOC indicated she was not aware of the first documented incident between resident #045 and #041. The DOC indicated that although managers, registered staff and the BSO team read daily report, and know about incidents, there was no monitoring of #045's responsive behaviours for trends.

During an interview on December 12, 2016, with Inspector #571, the Assistant Director of Care, who is the lead for the BSO team, indicated that the staff knew the triggers for resident #045's responsive behaviour. One trigger was identified and the home had put an intervention in place after the second documented incident to decrease the risk of behaviour.

During an interview on December 12, 2016 with Inspector #571, RPN #104, who worked on the unit where resident #045 and #041 resided indicated that the interventions implemented to keep resident #041 safe from #045 were implemented after altercations

During an interview on December 12, 2016 with Inspector #571, SW #102 who is also on the BSO team, indicated that after the second documented incident they put a new intervention in place to reduce the risk of altercations between resident #045 and #041.

A review of the care plan by Inspector #571 for resident #045 for a four month period in which the first and second documented altercations occurred, identified one specific trigger and one specific intervention.The care plan for a later four month period after the second altercation had occurred, indicated an additional intervention for the already

identified trigger. Hourly safety checks were put in place to keep resident #041 safe.

The licensee failed to ensure different approaches were considered when the plan of care was not effective when the plan of care was revised related to resident #045 continuing to have altercations with resident #041. [s. 6. (11) (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 for ensuring that the written plan of care for each resident who has bed rails, sets out, a) the planned care for the resident; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident; also, by ensuring the plan of care for each resident related to lifts and transfers is reviewed and revised when the resident's care needs change; and by ensuring that different approaches are considered when a resident's plan of care is being reviewed because the interventions were ineffective related to potentially harmful responsive behaviours, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a documented record was kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A review of the progress notes by Inspector #571, indicated that on a specified date, resident #025 informed RN #133 that resident #020 had verbally threatened to harm resident #025. Resident #025 indicated that he/she felt unsafe. RN #133 documented that several interventions were put into place to keep resident #025 safe including temporarily relocating resident #025

In an interview with Inspector #571 on December 14, 2016, the DOC indicated that although the home met the Ministry of Health's reporting requirements, she did not consider the incident as a complaint and did not record the complaint in the complaint log for the home.

The home failed to keep a written record of the verbal complaint received from resident #025. [s. 101. (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 for ensuring that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of an incident that caused an injury to a resident which resulted in a significant change in the resident's health condition and for which the resident is taken to a hospital.

The clinical record indicated that on a specified date, resident #025 complained of pain to a specific body part. The resident was sent to the hospital and returned from the hospital the same day with specific diagnoses. This injury resulted in a significant change in condition.

The clinical records also indicated that on a later specified date, the resident was transferred to the hospital for an injury that resulted in another significant change in conditon.

In an interview on December 15, 2016, with Inspector #571, the Director of Care (DOC) indicated that she did not report either of resident #025's injuries to the Director. [s. 107. (3) 4.]

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 for ensuring that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. An injury in respect of which a person is taken to hospital, to be implemented voluntarily.

WN #5: 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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Log #027177-16:

A CIR was submitted to the Director for a medication incident involving resident #002 which resulted in hospital admission.

A physicians order for resident #002 for a specific high risk medication was very specific in it's direcitons.

On a specified date, RPN #104 did not follow the directions for administration of the specific high risk medication and as a result resident #002 was sent to hospital for assessment and treated.

During an interview on December 16, 2016 with Inspector #194, RPN #104 indicated that he/she had not read the entire order.

Review of medication incident reports provided to Inspector #194 by the DOC identified that on a specified date RPN #104 administered resident #043's medication in error to resident #048. Resident #048 did not suffer any ill effect from the medication error.

During an interview on December 16, 2016, RPN #104 indicated to Inspector #194 that he/she had been distracted at the time of the medication administration which is what caused the error.

A review of a medication incident report on a specified date, RPN #130 administered a specified drug and dose to resident #002 in error.

The progress note completed by RPN #130 indicated that the RPN had made the error and that the Physician and family aware and had no concerns.

During a telephone a interview on December 20, 2016 with Inspector #194, RPN #130 indicated that while administering medication to resident #002 on a specified date, he/she had to attend to an urgent matter and as a result had to temporarily stop administering medication. RPN #130 explained that when he/she returned to the

medication pass he/she forgot that the specified medication had been already administered to resident #002 and re-administered the specified drug at a higher dose. [s. 131. (2)]

2. On a specified date and time, resident #047 was assessed by RPN #104 a medical directive had been implemented by RPN #130.

Review of the medical directives for resident #047 indicated that if a resident was displaying a specified symptom, then the nurse may implement a specific medical directive and notify MD immediately.

During an interview on December 16, 2016, RPN #104 indicated to Inspector #194 that he/she did not notify the physician because he/she had not initiated the medical directive RPN #104 also indicated to Inspector #194 that he/she was not clear on the directions to take when initiating the medical directive for the specific symptom, prior to the incident with resident #047.

During a telephone interview on December 20 , 2016 with Inspector #194, RPN #130 indicated that he/she initiated the medical directive for resident #047 on a specified date when resident #047 presented with specific symptoms. During the same telephone interview, RPN # 130 indicated to inspector that he/she did not notify the physician at the time of the implementation of the medical directive.

Review of the progress notes for resident #047 was completed by Inspector #194 for a specified time period of six days. On a specified date, the physician had documented that he/she was surprised to the medical directive implemented for resident #047 and that he/she was not informed of the symptoms that were present in the last several days. The progress notes indicated that resident #047 was treated a specific illness and treated by the physician.

During interview on December 16, 2016, RN #129 indicated that he/she was aware of the requirements for initiating the specified medical directive, that the physician was to be called immediately. Inspector #194 inquired if any incident of the specific medical directive being initiated at the home had occurred recently. RN #129 indicated that he/she was aware of three residents #058, #056 and #057 who required the specific medical directive in a specified month. Review of the clinical health records of the identified residents was completed by Inspector #194 and identified that resident #058 had the medical directive initiated on a specified date. During the same interview, RN

#129 indicated that when he/she arrived on shift on a specified date and been informed that the specified medical directive had been initiated the previous day, he/she immediately notified the physician.

Review of the clinical health record for resident #058 was completed by Inspector #194 and indicated that on a specified date resident #058 was assessed by RPN #131. The progress notes for resident #058 indicated that resident #058 had specific symptoms and that the specified medical intervention was initiated.

During telephone interview on December 21, 2016 with Inspector #194, RPN #131 indicated that he/she was the RPN who initiated the medical directive for resident #047 on the specified date and did not notify the physician after the medical directive was initiated.

The licensee failed to ensure that drugs are administered to resident #002, #047, #048 and #058 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 10th day of February, 2017

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

Original report signed by the inspector.

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

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA MATA (571), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2016_328571_0033
Log No. / Registre no:	013464-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 9, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE700, MARKHAM, ON, L3R-9W2
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 :	Deborah Woods

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 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) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall:

(a) educate all registered nursing staff, including agency registered nursing staff, related to the licensee's medication policy #RC-06-05-07 dated June 2016 "Medication Management" in a formal education session, and evaluate staff comprehension of the contents of the Policy following the session to ensure understanding; in particular the session and evaluation must include the requirement in the policy to administer medication within one hour of the scheduled time; the need to adhere to the eight rights when administering medications and compliance of the Medical Directive related to Oxygen administration; and,
(b) develop and implement a process to ensure that all staff who administer medication to residents adhere to the licensee's medication policy #RC-06-05-07 dated June 2016 "Medication Management", and to ensure that prompt action is taken in response to non-compliance with this policy and medication incidents.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the licensee's policy #RC-06-05-07 related to medication administration was complied with to ensure safe, effective administration of medication for resident #050, #051, #002, #053, #054 and #055.

O. Reg. 79/10, 114. (2) states the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, destruction and disposal of all drugs used in the home.

During medication administration observation on a specified date at a specified time, Inspector #194 observed that Registered Practical Nurse (RPN) #125 was administering medication to residents on the unit that should have been given three hours earlier. During an interview, RPN #125 indicated that he/she was administering medication three hours late. The RPN indicated to Inspector #194 during the same interview, that the medication pass was a heavy one. Inspector #194 asked if today was a usual day for medication administration and RPN #125 indicated that there had been a number of phone calls that day that he/she needed to answer.

Review by Inspector #194 of the licensee's medication policy #RC-06-05-07 dated June 2016 titled Medication Management, directs:
-scheduled medications will be administered according to standard medication administration times. Medication should be given within the recommended time frame, 60 minutes prior to and 60 minutes after the scheduled administration time.

Review of the physicians order audit report for day shifts identified:
-on a specified date-13 out of 36 residents were administered their medication outside the one and half hour time frame
-on a separate specified date-22 residents were administered medications late.

The clinical records reviewed by Inspector #194 indicated that resident #050 had specific diagnoses. The physician order audit report for resident #050 on a specified date identified that five medications were given approximately two hours after they were scheduled to be given and three drugs were given approximately two and a quarter hours late. This included three high risk drugs.

A review of the clinical records by Inspector #194 indicated that resident #051 had several specific diagnoses. The physician order audit report for resident #051 on a specified date identified that seven medications were given approximately two and a half hours after they were scheduled to be given. The second dose of a high risk medication was given only one hour and twenty minutes after the first dose was given. This medication was scheduled to be

given four hours apart.

A review of the clinical records by Inspector #194 indicated that resident #002 had several diagnoses. The physician order audit report for resident #002 dated on a specified date identified that 14 medications were given approximately three hours after they were scheduled to be given.
Three medications were administer two and a quarter hours after the first dose given and were actually scheduled to be given four hours apart.

A review of the clinical records by Inspector #194 indicated that resident #052 had several specified diagnoses. The physician order audit report for resident #052 on a specified date identified that nine medications were given over two and a half hours after they were scheduled to be given.

A review of the clinical record by Inspector #194 indicated that resident #054 had several diagnoses. The physician order audit report for resident #054 on a specified date, identified that two medications were given approximately three hours later than originally scheduled.

A review of the clinical record by Inspector #194 indicated that resident #055 had several specified diagnoses. The physician order audit report for resident #055 on a specified date, identified thirteen medications were administered approximately three and a half hours late.

The licensee has failed to ensure that the licensee's policy #RC-06-05-07 related to medication administration was followed to ensure safe, effective administration of medication for residents #050, #051, #002, #053, #054 and #055. [s. 8. (1) (b)] (194)

SEVERITY AND SCOPE STATEMENT FOR THE ORDER:

A compliance order is being issued under LTCHA s.8(1) for not complying with the licensee's medication policy #RC-06-05-07. The scope of the non compliance on the days identified was wide spread including the entire unit. The potential for injury was high related to a number of high risk medications ordered more than once per shift for resident's identified and were given in close proximity to each other. [s. 8. (1) (b)] (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 05, 2017

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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.

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
Inspection de soins de longue durée
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 9th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Patricia Mata

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