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 # / No de registre	Type of Inspection / Genre d’inspection
Dec 20, 2017	2017_694166_0029	013362-17	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

CAROLINE TOMPKINS (166), JENNIFER BATTEN (672), SAMI JAROUR (570)

Inspection Summary/Résumé de l’inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6, 7, 8, 11,12, 13, 18, 19, 2017

Complaint logs 018341-17 and 024684-17 related to resident care and Critical Incident(CIR) logs 021388-17, related to an allegation of staff to resident neglect and 22963-17, related to an allegation of resident to resident abuse were inspected concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, President of the Residents' Council, President of the Family Council, Physiotherapist, Program Manager, Activity Aide, Laundry Aide, Registered Dietitian, Restorative Aide, Personal Support Workers(PSW), Behaviourial Support Ontario(BSO), Registered Practical Nurses(RPN), Registered Nurses(RN), Maintenance, Resident Assessment Instrument Coordinator(RAI), Director of Care (DOC), Assistant Director of Care(ADOC) and the Administrator.
During the course of this inspection , the inspectors toured resident rooms and common areas, observed resident to resident interactions and staff to resident interactions during the provision of care . The inspectors observed a noon meal service, infection control practices and medication administration.
The inspectors reviewed clinical documentation, the licensee's investigation documentation and the licensee's policies related to Code Yellow procedures, Medication Incident reporting, Documentation Procedures, Management of Narcotics/ Controlled Drugs and Medication Management.

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
Nutrition and Hydration
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)
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	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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were kept closed and locked when not being supervised by staff.

During the initial tour of the home, on December 4, 2017 and on December 8, 11, 12, and December 18, Inspector #672 made the following observations:

First Floor –
• The Shower Room door could be pushed open, without entering the code into the lock keypad on the door. There were several residents sitting in the immediate area outside of the tub room and no staff members were observed in the immediate area.
• The supply closet beside the shower room had a key in the lock of the door. Inside the closet was a white, plastic 4 drawer cart, labelled from group one to four, and inside each drawer were medicated creams. There was also "All Purpose Disinfectant Cleaner", "Accel Intervention" cleaning wipes, and personal care items, such as razors, combs, and lotions stored within the closet. There were several residents sitting in the immediate area outside of the tub room and no staff members were observed in the immediate area.
• The Utility Room door was left propped open. This room had a fridge for specimen storage, and specimen supplies, along with a bottle of "Ecolab Easy Scrub Blue" disinfectant cleaner, and a 5L bottle of "Heinz" white vinegar under the sink. In the cupboard above the sink was a stored box of "BD Vacutainer Push Button Blood Collection Set", and urinary supplies, such as measuring devices, urinals, bedpans, basins, etc. There were several residents sitting in the immediate area outside of the tub room and no staff members were observed in the immediate area.
• The door to the Dining room was propped open, with residents sitting in the lounge area in front of the dining room. At the back of the dining room was a door with a "Staff Only" sign posted on it, which lead into the main kitchen. This door was not locked, and could be pushed open easily.

Second Floor –
• The door to the tub room was propped open. There were no staff members noted to be in the immediate area, and there were two residents noted to be in the hallway, wandering.
• The tub room in the 'short hallway' was noted to have the door propped open. No staff members were observed in the immediate area, and residents were noted to be wandering in the hallway, just outside of the area.

Third Floor –

• The door to the dining room could be pushed open, without entering the code into the keypad on the door, and there was one resident sitting inside the dining room, unsupervised.
• The door to the tub room in the 'short hallway' was noted to be propped open. No staff members were observed in the immediate area, and residents were noted to be wandering in the hallway.

During an interview on December 19, 2017, RPN #136 indicated that the expectation in the home was the doors to the tub, shower, and dining rooms were to be kept closed and locked at all times, when not in use. RPN #136 further indicated that the tub, shower, and dining rooms were considered to be non-residential areas, when staff members were not in the immediate area to supervise.
During an interview on December 19, 2017, the DOC indicated that the expectation in the home was that the doors to all non-residential areas were to be kept closed and locked at all times, if staff members were not in the immediate area to supervise. The DOC further indicated that the tub, shower, and dining rooms were considered to be non-residential areas, when staff members were not in the immediate area to supervise residents within those areas.

The licensee failed to ensure that all doors leading to non-residential areas were kept closed and locked when not being supervised by staff. [s. 9. (1) 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 the following rules are complied with: . All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the licensee's medication incidents and adverse drug reactions which occurred within the home between September 1, 2017 and November 30, 2017 was conducted by Inspector #672. It was noted that eleven medication incidents were reported during that time period. Review of three specific medication incidents indicated:

A medication incident report was submitted to the DOC by RN #135, which indicated that on a specific date resident #024 received a medication which exceeded the dose prescribed by the Physician's order.

Review of the medication incident report and interview with DOC, indicated that RN #135 made an error in the medication math, and realized the error following administration of the medication. The resident was assessed and and monitored post incident.

A medication incident report was submitted to the DOC related to resident #058. The incident report indicated that RN #137 did not administer an analgesic to resident #058 as per the physician's order. The error was noted during the shift change, when completing the narcotic count. The analgesic was administered to resident #058 when the error was discovered. The resident was assessed and monitored post incident.

A medication incident report was submitted to the DOC, involving resident #059. Resident #059 had a Physician's order for a medication treatment to be applied each morning and removed each evening. On a specified date the medication treatment was not removed and was found on the following day when the RPN went to apply the new medication treatment. The resident was assessed and monitored post incident.

The licensee has failed to ensure that drugs were administered to residents #024, #058, and #059 in accordance with the 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 #3: 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. (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 :

1. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and that corrective action was taken, as necessary.

Review of the licensee's medication incidents and adverse drug reactions which occurred within the home between September 1, 2017 and November 30, 2017 was conducted by Inspector #672. It was noted that eleven medication incidents occurred during that time period.

Inspector #672 reviewed the Professional Advisory Committee (PAC) minutes from meetings held on December 4, 2017, and September 25, 2017. There was no documentation within the minutes which reflected that the medication incidents and adverse drug reactions were analyzed for trends, or what the action plans or long term solutions were, in an attempt to prevent further incidents from occurring.

During an interview on December 13, 2017, the DOC indicated to Inspector #672 that the medication incidents from the previous quarter were discussed during the PAC meetings, but that the incidents were not analyzed for trends. The DOC further indicated that there was not any documentation to reflect any corrective action plans, in an attempt to prevent further medication incidents from occurring.

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, and that corrective action was taken, as necessary. [s. 135. (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, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b) of O. Reg. 79/10, s. 135 (2), to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #008 as specified in the plan.

Review of clinical documentation related to the falls' history for resident #008, indicated the resident was independent with mobility/ transfers, however resident #008 did have a history of falls, was on the Falling Star program and recently had several falls, as a result of the last fall, resident #008 sustained an injury.
Review of resident #008's plan of care related to falls indicated, the resident was use protective equipment to mitigate any injuries from falls.
During an interview, RPN#106, indicated, the protective equipment for resident #008 was not always available.

During separate interviews, RPN#106, PSW#107 and observation of resident #008, indicated at the time of this inspection, resident #008 was not using the protective equipment. The nursing staff were unable to locate the equipment, indicating the equipment had been sent for cleaning.

During an interview with Laundry Aide#108, who searched for the equipment , indicated the protective equipment for resident #008 was not located in the clean or the dirty laundry.

Resident #008 was not provided with protective equipment to mitigate injury from falls as specified in resident #008's plan of care. [s. 6. (7)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for resident #008 was based on an interdisciplinary assessment of the resident's communication abilities.

Review of resident #008's most recent assessment related to communication indicated: resident #008 had been noted to mix up words more and to misunderstand what has been said more often.
The assessments indicated :
Communication will be care planned with the goal of ensuring the resident's needs are met. Interventions are in place and are effective at this time.

Review of resident #008's plan of care did not identify any verbal or hearing communication abilities and did not identify any interventions in place in order to ensure the resident's needs related to communication were met. [s. 26. (3) 3.]

Issued on this 21st day of December, 2017

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

Original report signed by the inspector.