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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 31, 2018	2018_603194_0015	013993-18	Resident Quality Inspection

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

CHANTAL LAFRENIERE (194), COREY GREEN (722), 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): July 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26, 2018

Inspectors completed the following intakes during the Resident Quality Inspection (RQI); Critical Incident Inspection Log #001169-18; Log #001813-18; involving allegation of resident to resident abuse; Log #007633-18; Log #017563-18 involving allegations of staff to resident abuse; Log #002224-18; Log #003384-18; Log #006495-18 for falls; Log #004937-18 Complaint inspection involving concerns related to infection control practices and responsive behaviours; Log #005399-18 Complaint inspection involving concerns involving infection control practices and provision of resident care.

During the course of the inspection, the inspector(s) spoke with The Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Housekeeping staff, Janitor, Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Rai Co-ordinator, BSO/RPN, Infection Control Nurse, Registered Physio Therapist (RPT), Registered Physio Therapist Assistant (PTA), Restorative Aide, Physician, Social Worker (SW), Certified Public Health Inspector, Representatives of Resident Council and Family Councils.

The inspectors completed a tour of the building. The inspection team observed infection control practices, medication administration practices, provision of staff to resident care, reviewed clinical health records of identified residents, relevant policies, complaint procedure, staff educational records, outbreak records and Resident Council minutes

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
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.
- **8 WN(s)**
- **5 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 :

The licensee has failed to ensure that care set out in the plan of care related to prescribed pain medications were provided to resident #001 as specified in the plan.

Resident #001 was admitted to the home with diagnoses related to their musculoskeletal conditions and pain. Review of the resident's plan of care indicated that resident #001 did not receive prescribed pain medications as needed when pain was reported.

The Medical Directives for resident #001 were reviewed by Inspector #722 and indicated a prescribed pain medication was ordered as needed for the resident on admission.

On an identified date, a progress note indicated that the resident complained of pain in two separate areas. Eight days later, a progress note indicated that the resident complained of pain that interfered with their ability to transfer to the bed. Review of the electronic Medication Administration Record (eMAR) by Inspector #722 indicated that no as needed (PRN) pain medication was administered to resident #001 for pain on the two identified dates.

The following identified month, a progress note indicated that the resident had complained about their specific pain to the Behavioural Support Ontario (BSO) Team registered staff. Review of the eMAR indicated that no PRN pain medication was administered by the registered staff, and no other immediate pain management interventions were implemented.

Fifteen days later, a progress note for a physician visit indicated that the resident was seen by the physician and complained of specific pain. Review of the Physician's Orders indicated that a prescription was written for resident #001 for a topical treatment to be administered twice daily (BID), (PRN). Review of the eMAR indicated that no PRN pain medication was administered, and the electronic Treatment Administration Record (eTAR) was reviewed and indicated that no topical treatment was applied on the identified date.

The following day, the physiotherapist conducted a comprehensive physiotherapy assessment and indicated that resident #001 showed signs of being in pain. Review of the eMAR and eTAR by Inspector #722, indicated that no PRN pain medication was administered by the registered staff, and no topical treatment was applied, respectively, in response to resident #001's complaints of pain.

The following identified month, a progress note for a physician visit indicated that the resident was seen by the physician and complained of another area for pain; the Physician's Orders indicated that an order was written for resident #001, to apply the

topical treatment BID, PRN for pain. The eTAR indicated that no topical treatment had been applied, and the eMAR indicated that no PRN pain medication was administered by registered staff on the identified date.

Seven days later, a progress note for a physician visit indicated that the resident complained of pain. Review of the eTAR indicated that no topical treatment was applied; and the eMAR indicated that no PRN pain medication was administered by the registered staff.

Inspector #722 interviewed RPN #106 on an identified date related to resident #001's pain management. RPN #106 indicated that the Personal Support Workers (PSWs) can administer the topical treatment, and that they notify the RPN who will document in the eTAR that it has been applied. RPN #106 confirmed that the topical treatment was not signed as given in the eTAR for a specified period. RPN #106 also confirmed that a pain medication was available as a PRN under the medical directives for resident #001's pain, and could not identify any time that it had been administered since the resident was admitted to the home.

Inspector #722 interviewed RN #128, who confirmed that a pain assessment was completed on an identified date by RPN #125, where resident #001 reported pain, and that no PRN pain medication was administered and/or topical treatment applied according to the plan of care to address the resident's pain. RN #128 also confirmed that on an identified date, when new pain was identified and need for pain control were identified by the physician, that the resident was not assessed for pain by the registered nursing staff, no topical treatment was signed as being administered in the eTAR, no PRN pain medication was given as per the eMAR, and no new interventions were ordered and/or implemented to address the resident's pain.

Inspector #722 interviewed ADOC #118 on an identified date related to resident #001's pain management. ADOC confirmed that resident #001did not receive any doses of PRN pain medication or topical treatment as per the resident's plan of care, despite reporting pain to the physician and registered staff on a number of occasions over a specified period.

The licensee has failed to ensure that resident #001 received PRN pain medications for pain management as specified in the resident's plan of care.

2. The licensee has failed to ensure that care set out in the plan of care related to physiotherapy treatments to manage resident #001's pain was provided to the resident as specified in the plan.

Resident #001 was admitted to the home with diagnoses related to their musculoskeletal conditions and pain. Review of the resident's plan of care indicated that resident #001 did not receive physiotherapy treatments as ordered by the home's physiotherapist.

Inspector #722 reviewed the progress notes in the electronic health record for resident #001, which indicated that RPN #119 had made a referral to physiotherapy for pain management on an identified date.

The physiotherapy assessment for resident #001 completed the following day was reviewed by Inspector #722 and indicated that the resident showed signs of pain. The proposed interventions to address the resident's pain issues included specific treatment by the physiotherapy assistant (PTA), and to trial an adaptive aide for a few weeks.

Resident #001's current written care plan was reviewed by inspector #722, related to physiotherapy interventions. The interventions indicated in the written care plan included specific treatments to be provided by PTA three times per week, and of an adaptive aide for a few weeks.

Inspector #722 reviewed the Physiotherapy Daily Attendance record for resident #001 for a specified period, which indicated that resident #001 received only two physiotherapy treatments per week, not three treatments as per the written care plan, for a specified period. The Physiotherapy Daily Attendance record indicated that resident #001 refused one treatment during one of the identified period, so only two treatments were documented that week.

Inspector #722 interviewed PT #129 on an identified date related to the physiotherapy treatments for resident #001. During the interview, PT #129 confirmed that resident #001 was to receive treatments for pain management, as indicated in the current written care plan. PT #129 confirmed that, resident #001 received only two and not three physiotherapy treatments during the specified period.

PT #129 confirmed that the resident should have received three treatments in the period listed above as per the written care plan, and that there is no documentation that the resident refused and/or was offered treatment during that period.

The licensee has failed to ensure that resident #001 received physiotherapy treatments for pain management as specified in the resident's plan of care. [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 by ensuring that the care set out in the plan of care for resident #001 related to pain and physio is provided as specified., to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when pain related to residents #001, #008 and #011 was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to resident #008:

During interview with inspector #722 in stage 1 of the RQI, resident #008 indicated having a specified pain. During a follow up interview with inspector #194, resident #008 continued to express having the specified pain.

During interview with inspector #194 on an identified date, the DOC verified that the licensee's assessment instrument specifically designed for pain was the Pain Flow Note in Point Click Care (PCC).

Review of resident #008's clinical health record was completed and indicated medical condition which supported pain as an outcome. Resident #008 is cognitively well, able to direct their care, mobilizes in and out of the home with use of mobility device independently.

Review of the eMAR for a specific month, indicated that resident #008 was ordered a pain medication three times daily.

Review of the eMAR for resident #008, for the identified month, indicated that fourteen doses of PRN pain medication were administered to the resident. The progress notes indicated that the pain medication was administered for an expressed specific pain. One pain flow note was identified in the progress note for resident #008 during the reviewed period.

Review of the eMAR for the following month, indicated that a PRN pain medication, twice daily, was ordered for resident #008.

Review of the eMAR for resident #008, for the period of six days during identified month, indicated that fourteen doses of a PRN pain medication was administered to the resident. The progress notes indicated that the pain medication was administered for expressed specific pain. Three Pain Flow Notes were identified in the progress notes for resident #008 during the reviewed period.

During interview with inspector #194, RPN #119 indicated being aware that a Pain Flow Note was required when administering a PRN pain medication. RPN #119 confirmed administering PRN pain medications on three identified dates, and administering another PRN pain medication on three identified dates, but was unable to explain why a Pain Flow Note was not completed when the pain medications were administered.

Related to resident #011:

Review of resident #011's clinical health record was completed and indicated that the resident was cognitively well, able to direct their care and ambulated in the home independently.

Review of the eMAR for an identified month, for a period of one week, indicated that a pain medication was ordered routinely at bedtime for resident #011. The MAR indicated

that seven doses of PRN pain medications were administered to resident #011 during the reviewed period. Review of the progress notes for the period does not provide any Pain Flow Notes. were completed.

During interview with inspector #194 on an identified date, RN #108 indicated being aware that resident #011 was prescribed pain medication and felt that resident #011's pain was usually well managed. RN #108 indicated if a new pain was identified then a pain assessment would be completed and if medication was required a Pain Flow Note would be completed and a note left for the physician. RN #108 was unaware of any new pain onset for resident #011 when interviewed and was not able to provide any explanation for PRN pain medication being administered to the resident during the review period and no Pain Flow Note being completed.

During interview with inspector #194 on an identified date, RPN #107 indicated that resident #011 was ordered medication for pain management. RPN #107 indicated to inspector #194 during interview being aware that Pain Flow Note was to be completed with use of PRN pain medication or new pain medications.

Related to resident #001.

Review of the written plan of care indicated that on admission, resident #001 had diagnoses related to musculoskeletal issues and chronic pain.

On an identified date, resident #001 was interviewed by inspector #722 and indicated pain with no relief at the time of the interview. Resident #001 indicated that they have physiotherapy treatments that helps sometimes. Resident #001 indicated that they do not ask for pain medication and do not remember receiving anything for pain.

The progress notes for resident #001 were reviewed for a specific period, related to musculoskeletal issues and pain management. During this period, the progress notes indicated that the resident had specifically complained of pain on six separate occasions.

On admission, resident #001 was prescribed a number of routine pain medications, and none of these medications were changed over the specified period. The Physician's Orders for resident #001 were reviewed related to pain management. A topical treatment was ordered by the physician on an identified date to apply to specific areas twice daily as needed for pain; over a specific period and to apply to an other specific area, twice

daily as needed for pain.

Assessments in resident #001's electronic health record were reviewed for a specific period focusing on those related to pain. Two pain assessments were identified during this period using pain assessment instruments: an initial pain assessment was documented on the admission date, and a comprehensive pain assessment was completed by RPN #125 one month later. No other pain assessments using a pain assessment instrument were documented in the electronic health record by registered staff during this period. The physician completed five assessments during the reviewed period; no pain scores were provided and a clinically appropriate pain assessment instrument was not used. The physiotherapist completed a physiotherapy assessment on an identified date, which indicated a pain score, but a pain assessment tool was not used.

Inspector #722 interviewed RN #128 on an identified date related to resident #001's pain management. RN #128 indicated that the home has a pain assessment tool available to registered staff in the electronic health record, called a Pain Flow Note. RN #128 indicated that they were aware that the expectation is that the Pain Flow Note is to be completed by registered staff to assess the resident's pain, including when pain medication is administered to document the effect of the medication. RN #128 also indicated that the Pain Flow Note should be completed when a resident appears to be in any kind of discomfort, the resident is complaining of pain, displaying any non-verbal signs of pain, or exhibiting responsive behaviours that may suggest they are experiencing pain. Review of the progress notes by Inspector #722 for a specific period, for resident #001 indicated that there were no documented pain assessments using the Pain Flow Note completed by registered staff.

During the interview with Inspector #722 on an identified date, RN #128 also acknowledged that they were notified by the BSO Team on an identified date that resident #001 had "worsening pain". RN #128 confirmed that they did not conduct a pain assessment for resident #001, when BSO reported pain concerns, using the Pain Flow Note, or any other pain assessment tool, and that a pain assessment was not documented by any registered staff.

Inspector #722 interviewed RPN #106 on an identified date related to resident #001's pain management. RPN #106 indicated that they assess resident #001's pain three times each shift, at every med pass, including location, quality, and severity (i.e., score). RPN #106 indicated that the pain assessment is documented in the progress notes, and that

they chart by exception. RPN #106 indicated that if the resident does not report pain, that they do not enter any information regarding the pain assessment in the progress notes. RPN #106 indicated that they were aware that pain assessments should be entered into the Pain Flow Note in the electronic medical record, and confirmed that they did not document pain assessments for resident #001 using the Pain Flow Note. RPN #106 indicated that when they were notified of resident #001's "worsening pain" on an identified date, by the BSO Team, that they assessed the resident's pain, but did not use a pain assessment tool and did not document the pain assessment.

Associate Director of Care (ADOC) #118 was interviewed by inspector #722 on an identified date. During the interview, ADOC #118 confirmed that according to the pain management policy in the home, registered staff should be assessing residents for any new or worsening pain and documenting their findings using the Pain Flow Note available in the electronic health record. ADOC #118 verified that pain assessments should have been completed and documented using a Pain Flow Note specifically on seven separate identified dates, corresponding to days when the resident complained of pain and/or a new intervention was implemented to manage resident #001's pain.

The licensee failed to ensure that when residents #001, #008 and #011 pain worsened and was not relieved by initial interventions, that the resident was assessed using the Pain Flow Notes available in the electronic health record, or any clinically appropriate assessment instrument specifically designed for pain. [s. 52. (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 by ensuring that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the following requirement was met with respect to the restraining of a resident by a physical device. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions.

Related to Log#006495-18:

A critical incident report was submitted to the Director on an identified date for a fall incident that occurred involving resident #020 with no injuries noted. The resident was transferred to hospital and was diagnosed with an injury. The resident required the use of mobility device due to a change in mobility status.

Review of clinical records for resident #020 indicated the resident was assessed at high risk for falls on admission.

On an identified date, resident #020 was observed by inspector #570 to have restraint applied while in mobility device. Inspector noted the restraint was altered and that the restraint was improperly attached to the mobility device. The resident was unable to unfasten the restraint when asked by the Inspector.

The following day, resident #020 was observed by inspector #570 in the presence of ADOC #118, to have a restraint applied while in mobility device. During the observation it was noted that the restraint had been altered and was improperly attached to the mobility device.

Two days later, interview with PSW #130, indicated that the resident had a restraint in use and the restraint had been altered, for a specific period. The PSW indicated not being sure who altered the restraint, but indicated that it could have been used to prevent the resident from releasing the restraint when fiddling with it.

The same day, interview with RN #142, indicated that the resident had a restraint when in mobility device. The RN indicated no awareness that the restraint had been altered or that the restraint was improperly attached to the mobility device.

The following day, during an interview, the PTA#132 indicated resident #020 had a restraint when in mobility device. PTA #132 indicated they noticed the restraint had been altered, over a specific period and that it had been corrected at that time.

On the same day, during an interview, the physiotherapist #129 indicated that resident #020 had a restraint in place when in mobility device. The physiotherapist indicated that they were not aware that the restraint had been altered or improperly attached to the mobility device. The physiotherapist further indicated that the restraint used for resident #020 should not be altered.

On the same day, during an interview, the assistant Director Of Care (ADOC) #118 confirmed that the resident was using a restraint as per family request. The ADOC indicated that they were unaware that the restraint was altered and improperly attached to the mobility device and the home's policy directs that they do not alter any restraint.

Review of the manufacture's instructions, provided by ADOC #118, related to the use of the identified restraint, did not indicate that the device should be altered in the manner in which the restraint was found by inspector #570.

The restraint used for resident #020 was noted to be altered an improperly attached to the mobility device [s. 110. (1) 3.]

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 by ensuring that physical devices are not altered except for routine adjustments in accordance with any manufacturer's instructions, 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 licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to medication incident #1:

Inspector #722 reviewed the medication incident report #1 that occurred on an identified date, involving resident #016. Medication incident #1 indicated that the medication pouch for resident #016, on an identified shift was found on the following shift by RN #115(ADOC) with the identified medication still in the pouch. The identified medication had not been administered.

The physician's orders were reviewed for an identified month, and indicated that the identified medication was to be administered twice daily. The eMAR reviewed indicated that the identified medication dose for resident #016 on the identified shift, was signed as given by RPN #116.

Inspector #722 interviewed the Director of Care (DOC) #101 on an identified date, related to the medication incident #1, involving resident #016. The DOC confirmed during the interview that resident #016 was not administered the identified medication, as prescribed by the physician.

Related to medication incident #2:

Inspector #722 reviewed the medication incident report #2 that occurred on an identified date, involving resident #029. The medication incident indicated that the resident's identified medication which had been applied at a specific time was to be removed at a specific time, but was found on the resident the following shift. The identified medication

was signed as being removed by RPN #106.

The Physician's Orders were reviewed for resident #016 and indicated that the identified medication was to be applied and removed at a specific times. The eMAR was reviewed and indicated that the identified medication was signed as being applied by RPN #107 and it was signed as being removed by RPN #106 on the identified date.

Inspector #722 interviewed RN #115 the ADOC, an identified date, related to medication incident #2 and confirmed that the incident had occurred as described in the report, and that the resident #016's identified medication had not been removed as per the physician's order.

Related to medication incident #3:

Inspector #722 reviewed the medication incident report #3 that occurred on an identified date, involving resident #033, which indicated that the resident had received an extra dose of pain medication on an identified date by RN #108.

The physician's orders were reviewed for resident #033 and indicated that a pain medication was to be administered every 12 hours; there were no changes for this medication in the physician's orders leading up to the date of this medication incident. The eMAR was reviewed for the identified month and indicated that the pain medication was to be given at two specific times; the pain medication dose was signed as given on the identified date by RPN #108.

Progress notes were reviewed related to this medication incident and a medication administration note was entered on an identified date, indicating that an extra dose of pain medication was administered to resident #033.

Inspector #722 interviewed RN #115 related to this medication incident; the RN confirmed that the incident had occurred as described in the report, and that an extra dose of pain medication was administered to resident #033 on the identified date.

During stage 1 of the RQI resident #008 indicated having specific pain to inspectors #722 and #194.

Review of resident #008's clinical health record was completed and indicated medical diagnoses supporting outcome of pain. Resident #008 is cognitively intact, able to direct

their care, mobilizes in and out of the home with use of a mobility device independently.

Review of the clinical health record indicated the onset of the specific pain for resident #008 to be on an identified date.

Review of the physician's orders and eMARS for resident #008 for the month following the onset of specific pain indicated that a PRN pain medication, up to twice daily was ordered . On an identified date the eMARS and Individual Monitored Medication Record indicated that resident #008 was administered three doses of PRN pain medication. Review of the eMARS indicated that RPN #119 administered the third dose of PRN pain medication on an identified date.

During interview with inspector #194 on an identified date, RPN #119 reviewed the eMARS and progress notes for resident #008. RPN #119 indicated being aware that the pain medication was ordered as twice daily as required but was unable to explain why the pain medication was administered three time that day, when ordered as twice daily. (194)

The licensee failed to ensure residents #016, # 029, #033 and #008 drugs were administered in accordance with the direction 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 by ensuring that drugs are administered to residents in accordance with the direction for use specified by the prescriber, to be implemented voluntarily.

WN #5: 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).

Findings/Faits saillants :

1. The licensee has failed to 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.

Related to medication incident #1:

Inspector #722 reviewed the initial notification and final report for medication incident #1. The medication incident indicated that the medication pouch for resident #016, on an identified shift was found on the following shift by RN #115(ADOC) with the identified medication still in the pouch. The identified medication had not been administered. This incident was reported by RN #115 on an identified date and the medication incident report completed, which indicated that the resident did not experience any adverse reaction. The medication incident report did not include any information relating to immediate actions taken to assess and maintain the resident's health

The progress notes, assessments and vital signs were reviewed in resident #016's electronic medical record for identified period, and there were no entries related to this medication incident, no instructions for monitoring resident #016's condition, and no assessments were documented.

Inspector #722 interviewed RN #115 (ADOC) on an identified date related to medication incident #1. RN #115 indicated that they notified the physician and substitute decision maker (SDM) about the incident. RN #115 indicated that they did not recall assessing the resident after the medication incident was discovered, and indicated that this may have

been because it was a missed dose. RN #115 indicated that if they had assessed the resident after the medication incident was discovered, it would have been documented in the progress notes. RN #115 confirmed that there was no assessment documented in the progress notes on the identified date for resident #016. RN #115 also confirmed that there were no instructions/actions related to the resident's health provided by registered staff and/or the physician in relation to the missed dose.

Inspector #722 interviewed DOC #101 and RN #118 (ADOC) together on an identified date, related to medication incident #1 involving resident #016. When asked what immediate actions were taken to assess and maintain the resident's health, and where that was documented, both the DOC and ADOC indicated that any actions should be documented in the progress notes. RN #118 had earlier reviewed the progress notes for resident #016 and confirmed in the interview with Inspector #722, that there were no progress notes related to this medication incident. When asked about the expectations in terms of identifying actions to take to assess and maintain the resident's health, both the DOC and ADOC indicated that registered staff should contact the doctor to get directions related to a medication incident when it is identified. Both the DOC and ADOC also confirmed that there were no instructions provided by the doctor in terms of actions to take to assess and maintain the resident's health; and indicated that if an order had been given (e.g., monitor resident, assess vitals, etc.), it would have been documented in the progress notes, along with the assessments.

Related to medication incident #2:

Inspector #722 reviewed the medication incident report #2 that occurred on an identified date, involving resident #029, which indicated that the resident's identified medication that had been applied at a specific time was to be removed at a specific time, was found on the resident the following shift. The identified medication was signed as being removed by RPN #106. The incident report indicated that a medication incident had occurred and reached the resident, but the resident did not experience any adverse reaction. There was no information identified by Inspector #722 in the incident report that indicated the resident's condition and/or any assessments that were done when the incident was discovered and/or reported.

Progress notes were reviewed related to this medication incident and any actions taken to assess and maintain the resident's health. On an identified date, a medication administration note indicated that the identified medication was not administered because it was not removed. The progress note indicated that the physician was notified

of the incident and ordered that the identified medication was to be put on and removed at specific times. There were no progress notes, assessments, or vital signs (including blood pressure measurements) in resident #016's electronic health chart indicating any actions related to the resident, or that an assessment had been done when the incident was discovered.

Inspector #722 interviewed RN #115 (ADOC) on an identified date related to medication incident #2 , who confirmed that the identified medication was applied to resident #029, and remained on the resident until the following day, rather than being removed as ordered. The ADOC confirmed the details as written in the medication incident report. RN #115 also confirmed, after reviewing the resident's electronic health record, that there was no indication that the resident was assessed after the medication incident was identified; there were no progress notes indicating that an assessment had been done, no physician note regarding the incident, and no vital signs were assessed.

The licensee failed to ensure that two medication incidents, one involving resident #016 and another involving resident #029, were documented, together with a record of the immediate actions taken to assess and maintain the residents' health. [s. 135. (1)]

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 by ensuring 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents

During the tour of the building on an identified date, inspector #194 observed a number of residents outside in an organized resident space defined as the smoking area of the home. The area is located at the south side of the building, has a coded door and utilized by residents and families. The area did not have a resident-staff communication and response system available.

During interview with inspector #194 on an identified date, DOC and Administrator confirmed that there was no resident-staff communication and response system available for the smoking area, which is accessible to residents .

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by the residents. [s. 17. (1) (e)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every allegation of staff to resident physical abuse, involving resident #036, was immediately investigated.

Related to Log #007633-18:

A critical incident report was submitted on an identified date, for an allegation of staff to resident neglect. The CIR indicated on an identified date, PSW #148 was providing toileting care when the PSW observed the resident to be soiled. During the provision of care, the resident was visually upset and uncomfortable.

On an identified date interview with PSW #148 indicated that they reported the incident to charge nurse RN #115.

On an identified date, interview with RN #115 indicated that they became aware of the incident the following day, when informed by a family member of resident #034. RN #115 indicated that the ADOC #118 was informed of the incident in the following day. RN #115 indicated to Inspector #570 that they were in charge of the home when they became aware of the incident but did not report the allegation to managers on call or the MOHLTC as they did not believe it was a neglect situation. The RN further indicated that knowing the facts afterwards, the allegation should have been immediately reported and investigated.

A review of resident #034's progress notes revealed RN #115 completed a head to toe skin assessment for resident #034, 2 days after becoming aware to the allegations. The skin assessment revealed that resident #034 had compromised skin integrity in the specific areas.

On an identified date, during an interview, the Administrator indicated to Inspector #570 that managers on call were not notified of the allegation of staff to resident neglect when reported to the charge RN #115 on the identified date. The Administrator further indicated the allegation was immediately investigated when reported to the Administrator by end of following day.

The licensee had failed to ensure that the allegation of staff to resident neglect involving resident #034 was immediately investigated, after it was reported to RN #115 on an identified date. [s. 23. (1) (a)]

WN #8: 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 licensee had failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director: 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.

Related to Log #007633-18:

A critical incident report was submitted on an identified date, for an allegation of staff to resident neglect. The CIR indicated on an identified date, PSW #148 was providing toileting care when the PSW observed the resident to be soiled. During the provision of care, the resident was visually upset and uncomfortable.

The incident related to CIR was called in by the DOC using the LTC Home Emergency Pager, MOHLTC 2 days later.

On an identified date interview with PSW #148 indicated that they reported the incident to charge nurse RN #115 on the identified date.

On an identified date, interview with RN #115 indicated that they became aware of the incident the following day, when informed by a family member of resident #034. RN #115 indicated that the ADOC #118 was informed of the incident in the following day. RN #115 indicated to Inspector #570 that they were in charge of the home when they became aware of the incident but did not report the allegation to managers on call or the MOHLTC as they did not believe it was a neglect situation. The RN further indicated that knowing the facts afterwards, the allegation should have been immediately reported

On an identified date, during an interview, the Administrator indicated to Inspector #570 that managers on call were not notified of the allegation of staff to resident neglect when reported to the charge RN #115 on the identified date. The Administrator further indicated the allegation was immediately investigated when reported to the Administrator by end of following day.

The Licensee has failed to immediately report neglect of a resident by staff to the Director until 2 days after the incident and one day after the evening RN became aware of the allegation. [s. 24. (1)]

Issued on this 5th day of November, 2018

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

Original report signed by the inspector.