Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Hamilton District
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Original Public Report

Report Issue Date: August 21, 2024
Inspection Number: 2024-1342-0002
Inspection Type: Complaint Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 8, 9, 12, 13, 14, 15, 16, 2024.

The following intake(s) were inspected:

- Intake: #00119284 - Complaint related to administration of drugs and nutrition and hydration.
- Intake: #00120761 - Critical Incident (CI) 2857-000015-24 - related to alleged abuse of a resident.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Food, Nutrition and Hydration

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication management system

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (2)
Medication management system
s. 123 (2) 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, and destruction and disposal of all drugs used in the home.

The licensee has failed to ensure that they had written policies and protocols developed for the accurate acquisition, receipt, and destruction and disposal of medications brought in from a pharmacy that was not the home's contracted pharmacy.

Rationale and Summary
A resident had an order for the administration of a medication. This medication was being dispensed by a pharmacy that was not the home's contracted pharmacy. The home did not have a process in place for keeping track of when the medication was being delivered to ensure accuracy of the acquisition and receipt of this medication. There was an issue with the count of this medication at one point in time and an allegation of a missed dose. The home completed an investigation. Because the home failed to have a process in place for acquisition and receipt of medications

that did not come from their pharmacy they were not able to identify what had happened with the alleged missed dose. The Executive Director (ED) and Director of Care (DOC) confirmed that this was the gap and moving forward they had implemented a new process.

Failing to have policies and protocols in place for accurate acquisition and receipt of medications that were not dispensed by their own pharmacy increased the risk for medication errors.

Sources: Review of resident's health records, medication incident, investigation notes, client services response form; interview with registered staff, DOC and ED.