Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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

Division des foyers de soins de longue durée
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
Nov 7, 2019	2019_638542_0028	017780-19	Follow up

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 Falconbridge
281 Falconbridge Road SUDBURY ON P3A 5K4

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

JENNIFER LAURICELLA (542), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): October 10, 16-18, 21-25, 2019.

A Complaint inspection #2019_638542_0027 and a Critical Incident inspection #2019_638542_0029 were conducted concurrently with this Follow Up inspection.

One Follow Up intake for Compliance Order #001 from Inspection #2019_657681_0023, issued on September 09, 2019, regarding r. 131. (2) related to Medication Administration, with a Compliance Due Date of October 7, 2019, was completed.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

Inspectors conducted observations of the provision of care to the residents, reviewed resident health care records and relevant policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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. 131. (2)	CO #001	2019_657681_0023	542

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director, outlining concerns regarding medication administration for resident #002.

Inspector #542 reviewed resident #002's health care record. It was documented in the progress notes, that resident #002 did not receive the correct dosage of one of their medications. It was documented in the progress notes that the medication card had the wrong dosage of tablets in each slot, however the label had indicated the correct dosage. The RPN, administered, the wrong dosage of medication to resident #002 three times on a specific day, instead of the dosage prescribed by the physician.

Inspector #542 interviewed the Director of Care who verified that the medication error was originally a pharmacy error due to incorrect packaging.

This Non-Compliance supports Compliance Order #001 from Inspection #2019_657681_0023 which had a compliance due date of October 7, 2019. This non-compliance occurred prior to the due date of October 7, 2019, thus a Written Notification was issued. [s. 131. (2)]

Issued on this 8th day of November, 2019

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

Original report signed by the inspector.