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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 14, 2014	2014_283544_0006	S-000475-13	Complaint

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 FALCONBRIDGE
281 FALCONBRIDGE ROAD, SUDBURY, ON, P3A-5K4

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

FRANCA MCMILLAN (544)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 12, 13, 2014

Log # S-000475-13

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Assistant Directors of Care (ADOCs), Registered Staff, RAI/MDS Co-ordinator, Staff Education Co-ordinator, Personal Support Workers (PSWs) and Residents.

During the course of the inspection, the inspector(s) observed daily the direct delivery of care and services to the residents, observed staff to resident interactions, observed the delivery of medications to the residents, reviewed the residents' health care records, care plans and medication administration records, reviewed the homes policy regarding Prevention of Abuse and Medciation Administration, reviewed staff education, training and staff attendance records in regards to the Prevention of Abuse Policy.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 121. Every licensee of a long-term care home shall ensure that a system is developed for notifying the pharmacy service provider within 24 hours of the admission, medical absence, psychiatric absence, discharge, and death of a resident. O. Reg. 79/10, s. 121.

Findings/Faits saillants :

1. Although the licensee has a system in place for notifying the pharmacy service provider within 24 hours of admission, medical absence, psychiatric absence, discharge and death of a resident for long-stay residents, the licensee has no system in place for residents who are admitted to the Short Stay Program.
Resident # 001, who was admitted to the long-term care home did receive medications, as ordered by the physician, for the duration of the short-stay. The Best Practice Medication and History Reconciliation/Admission Orders sheet was checked off as "New Admission" and thus, Resident # 001 was identified as a new long-stay resident admission.
Inspector # 544, reviewed the Best Practice Medication History Reconciliation/Admission Orders and noted that there are only two (2) check off boxes:
a) New Admission
b) Re-Admission
There is no area, check off box or option to identify a resident admitted into the the Respite Stay or Short-Stay Program.
The medications are packaged individually with the resident's name, the medication name and the medication dosage and provided by Pharmacy as the service provider for the home.
A seven (7) day medication supply is prepared weekly by the long-term care home's pharmacy service provider on Wednesday of each week and delivered to the home on Thursday night of each week.
The pharmacy service provider was notified of the discharge of Resident # 001, after he left however, the medications arrived at the home on the day after the discharge. The medication was delivered to the home by the pharmacy because the " New Admission" box was checked off.
This was confirmed by the Assistant Director of Care. The Best Practice Medication History Reconciliation/Admission Orders sheet was reviewed by the Inspector with the Director of Care and three Assistant Directors of Care for the Home.
When Resident # 001 was discharged from the Home, family attempted to have the prescriptions filled at their local pharmacy and could not, because the medication was already dispensed by the pharmacy service provider to the long-term care home. After the family member of Resident # 001 explained what had happened, the Resident's local pharmacy dispensed the medication as ordered. Resident # 001 did not receive medication for one (1) day before the matter could be settled.
The licensee did not ensure that a system is in place for notifying the pharmacy service provider within 24 hours of admission, medical absence, psychiatric absence, discharge, and death of a resident. [s. 121.]

Issued on this 14th day of February, 2014

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

#544