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

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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
Jul 3, 2014	2014_293554_0019	O-001234-13	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE HALIBURTON
167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0

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

KELLY BURNS (554)

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): May 23, 2014

Complaint Inspection for Log #O-001234-13

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care, Registered Nursing Staff, Personal Support Workers, Residents and Family

During the course of the inspection, the inspector(s) tour of the home, review of resident health records, reviewed medication administration, reviewed the home's policies pertaining to: Medication Pass, Self-Administration of Medications

The following Inspection Protocols were used during this inspection:
Medication
Reporting and Complaints

Findings of Non-Compliance were found during this inspection.

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer’s instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. Related to Log #O-001234-13, for Resident #002:

The licensee failed to comply with O. Reg. 129.(1)(a)(ii), by failing to ensure that drugs are stored in an area, that is secure and locked.

Resident #002 was observed, to have the following medications in resident's possession:
- Spirvia Inhalation (capsules and handihaler)– 2 inhalers with accompanying medication capsules
- Ventolin Inhalation – 4 inhalers
- Advair – 2 inhalers
- ReFresh Opthalamic Drops – 1 bottle
- Lacri Lube Opthalamic Ointment – 2 containers
- Isopto Tears 1% - 1 bottle
- Nitroglycerin Spray – 1 bottle

The medications listed above were observed in a plastic baggie on the resident’s bed.

Resident #002 indicated that the medications were normally stored on the resident's bed or under the pillow during the day, and at night, places the medications on the shelf, beside the bed in a plastic container. Resident indicated that the medications are not stored in a locked container in the room. Resident #002 indicated no awareness of the need for the medications to be locked in a safety box.

Resident #002 resides in a room shared by three other residents.

Resident #005 was observed wandering into Resident #002's room, Resident #005 is at risk of ingesting substances and items in which resident shouldn't.

Staff #101 and #103 both indicated no awareness of Resident #002 needing a locked area to store medication when the medications were being self-administered.

Administrator/Director of Care indicated awareness of the need for medications to be safely stored in a locked area or medication cart, but indicated no awareness of Resident #002 having the medications in resident's room. [s. 129. (1) (a)]

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 stored in an area, that is secure and locked., 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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).

s. 131. (7) The licensee shall ensure that no resident who is permitted to administer a drug to himself or herself under subsection (5) keeps the drug on his or her person or in his or her room except,
(a) as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident; and O. Reg. 79/10, s. 131 (7).
(b) in accordance with any conditions that are imposed by the physician, the registered nurse in the extended class or other prescriber. O. Reg. 79/10, s. 131 (7).

Findings/Faits saillants :

1. Related to Log #O-001234-13, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s. 131(1), by failing to ensure that no drug is used by a resident in the home unless the drug has been prescribed for the resident.

The following medications were observed in the possession of Resident #002:
- Tums Plus

- ReFresh Ophthalmic Drops
- Isopto Tears 1% Ophthalmic Drops

The Physician’s Order Review, for the period reviewed, failed to demonstrate evidence of Resident #002 having a physician’s order for the above medications.

Interviews with Staff #101 and #103 indicated no awareness of Resident #002 having the medications. [s. 131. (1)]

2. Related to Log #O-001234-13, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s. 131(2), by failing to ensure that drugs are administered to resident’s in accordance with directions for use by the prescriber.

Resident #002, indicated, that the following medications, dosages and frequency were being self-administered:
- Spirvia Inhalation, one puff in the morning and at night
- Advair Inhalation, one puff in the morning, at lunch and a supper
- Ventolin (Salbutamol) Inhalation, one puff in the morning, lunch and at night
- LacriLube Ophthalmic Ointment, in the morning and at night to both eyes

The Physician’s Order Review, for the period reviewed indicated the above medications were prescribed as follows:
- Sprivia Inhalation, 18mcg, one capsule with handihaler daily
- Advair Inhalation, 50/500mcg, one inhalation twice daily (0800 and 1800)
- Ventolin (Salbutamol) Inhalation, 100mcg, shake well and inhale two puffs four times daily
- LacriLube Ophthalmic Ointment, apply in each eye at bedtime when needed

The Medication Administration Record for the period reviewed shows no documentation of administration of the above medications by neither Resident #002 nor registered nursing staff.

Staff #103 indicated no awareness of Resident #002 over or under using medications prescribed, stating resident self-administers the medication; staff indicated that there currently is no process in place to monitor self-administration practices that staff is aware of for Resident #002.

Staff #101 indicated no awareness of Resident administering eye ointment, but was aware of Resident #002 self-administering some of the ordered inhalations. Staff #101 indicated no awareness of Resident #002 not following the directions of the physician for medications being self-administered. [s. 131. (2)]

3. Related to Log #O-001234-13, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s. 131(7), by failing to ensure that no resident who is permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician or other prescriber who attends to the resident.

The following medications were observed to be in the possession of Resident #002:
- Spiriva Inhalation, 18mcg
- Lacri Lube Opthalamic Ointment
- Nitroglycerin Spray

Resident #002 indicated that Spiriva and Lacri Lube are used on a daily basis and the Nitroglycerin spray is used as needed.

A review of the Physician’s Order Review for the period reviewed, failed to identify that there were orders for Resident #002 to keep the medications on his or her person.

Staff #101 and #103 were not aware of Resident #002 having the Lacri Lube nor the Nitroglycerin spray; the Administrator-Director of Care had no awareness of Resident #002 having the medications in resident’s room. [s. 131. (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 to ensure that no drug is used by a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. Related to Log #O-001234-13, for Resident #002:

The licensee failed to comply with O. Reg. 79/10, s. 126, by failing to ensure that drugs remain in the original labeled container or package provided by the pharmacy service provider.

Resident #002, was observed with a plastic baggie containing a six foiled blister packets containing capsules of Spirvia for use in the handihaler; the medication capsules were not in the original labeled package and did not contain resident’s name or directions for use. [s. 126.]

Issued on this 4th day of July, 2014

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