Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Dec 30, 2019	2019_694166_0028	018039-19, 018324-19	Complaint

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 Haliburton
167 Park Street P.O. Box 780 HALIBURTON ON K0M 1S0

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

CAROLINE TOMPKINS (166)

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): December 9, 10, 11,12, 13, 2019.

The following complaint logs were inspected:
Log #018039-19, related to resident care.
Log #018324-19, related medication administration and Resident's rights.

During the course of the inspection, the inspector(s) spoke with Residents, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), Physiotherapist (PT), Substitute Decision Maker (SDM) and the Director of Care (DOC).

During the course of this inspection, the Inspector observed staff to resident interactions during the provision of care, reviewed specific residents' clinical health records, medication administration incidents, the licensee's investigation documentation and the licensee's policies related to medication management and falls prevention.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 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 resident #003:

The Substitute Decision Maker (SDM) for resident #003, submitted a complaint to the Director related to consent and medication administration.

Inspector #166, reviewed resident #003's clinical health records, which indicated a PSW had notified RN #104 that resident #003 was expressing discomfort. RN #104 assessed the resident and found the resident to be drowsy as well as in discomfort.

Inspector #166, reviewed the physician's order, which indicated resident #003 had been ordered a specific dosage of a medication.

Review of the medication administration records and review of resident #003's health records, by Inspector #166, indicated that RN #104 had administered to resident #003, one half the dosage of the medication that had been ordered by the physician.

During an interview with Inspector #166, the Director of Care (DOC) confirmed that RN #104 had assessed resident #003 and had made the decision, without notifying the physician, to administer one half the dosage of the medication that had been prescribed for the resident.

The licensee has failed to ensure that the medication, administered to resident #003 was in accordance with the directions 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 to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #2: 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. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all medication incidents are documented and corrective action is taken.

Related to resident #003:

Inspector #166, reviewed resident #003's clinical health records, which indicated a PSW had notified RN #104 that resident #003 was expressing discomfort. RN #104 assessed the resident and found the resident to be drowsy as well as in discomfort.

Inspector #166, reviewed the physician's order, which indicated resident #003 had been ordered a specific dosage of a medication.

Review of the medication administration records and review of resident #003's health records, by Inspector #166, indicated that RN #104 had administered to resident #003, one half the dosage of the medication, that had been ordered by the physician.

Inspector #166, reviewed the licensee's medication incident reports was not able locate any record of the medication incident related to resident #003. During an interview with Inspector #166, the Director of Care (DOC) confirmed that the medication incident involving RN #104 had not been documented and no corrective action had been taken when RN #104, made the decision, without notifying the physician, to administer half the dose of the medication that had been prescribed for resident #003.

The licensee has failed to ensure that the medication incident involving resident #003 was documented, corrective action was taken as necessary and a written record was kept of everything required. [s. 135. (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 the licensee shall ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required, to be implemented voluntarily.

Issued on this 7th day of January, 2020

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

Original report signed by the inspector.