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
Sep 3, 2019	2019_671684_0029	012631-19, 013645-19	Critical Incident System

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 Kirkland Lake
155 Government Road East KIRKLAND LAKE ON P2N 3P4

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

SHELLEY MURPHY (684)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 20-22, 2019.

The following intakes were inspected during this Critical Incident Inspection:

-One log related to falls prevention; and,

-One log related to medications.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Restorative Care Assistant, Registered Nurse (RN), Registered Practical Nurses (RPNs), Health Care Aide (HCA), residents and families.

The Inspector also conducted daily tours of the resident care areas, observed provision of care and services to residents, reviewed relevant licensee policies, procedures, internal investigation notes, and resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Inspector #684 reviewed a Critical Incident (CI) report, for an incident involving resident #001.

Inspector #684 reviewed resident #001's progress notes which described the incident that occurred, where resident #001 sustained an injury.

On two separate occasions, Inspector #684 observed a specified intervention being utilized for resident #001.

During a review of resident #001's care plan which was in place at the time of the incident, Inspector #684 was unable to locate the requirement for the specified intervention resident #001 utilized. Resident #001's current care plan was also reviewed, and Inspector #684 was unable to locate the specified intervention.

Inspector #684 interviewed Registered Nurse (RN) #101 and asked, how would you know if a resident required a specified intervention for care. RN #101 stated "It should be in their care plan". Inspector then asked Registered Practical Nurse (RPN) #104 the same question and they stated that resident #001 used the specified intervention and that it should be identified in their care plan. RPN #104 reviewed the care plan for resident #001 and was unable to locate the specified intervention.

Inspector #684 reviewed the home's policy titled "Plan of Care", RC-05-01-01, last updated June 2019. The policy stated "The plan of care will be reflective of the resident's goals and preferences through collaboration with the resident/SDM. As the resident's status changes, member of the interdisciplinary team are to update the plan of care so that at any point in time, the plan of care continues to be reflective of the current needs and preferences of the resident."

During an interview with Inspector #684, the Director of Care (DOC) stated that a resident who used a specified intervention would be documented in the care plan. Inspector #684 and the DOC reviewed the care plan for resident #001 from time of the incident as well as the current care plan to look for the specified intervention. The DOC confirmed to Inspector #684 that the specified intervention was not noted in the care plan either at the time of the incident or now. [s. 6. (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 there is a written plan of care for each resident that sets out, the planned care for the resident, 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Upon review of a CI report which was submitted to the Director for medication incident/adverse drug reaction critical incident, the Inspector identified that it was documented that resident #002 was administered an incorrect medication.

Inspector #684 reviewed the documentation for a "Medication Incident" form which indicated the type of incident. Resident #002 was the resident involved in the incident, it was identified under Additional Notes: "College of Nurses of Ontario (CNO) standards on medication administration were not followed and were the cause of error."

Inspector #684 further reviewed documentation which was submitted to the CNO regarding the incident which indicated the following for the two staff members involved.
Specific to RN #105, it was documented that RN #105 failed to follow CNO standards on medication administration.
Specific to RPN #106, the Inspector noted the following documentation:
RPN #106 failed to follow CNO standards on medication administration.

Inspector #684 reviewed the home's policy titled "Medication Management", RC-16-01-07, last updated February 2018, as per policy, "Administer medications following the 8 "Rights" of medication administration:
a) Right resident
b) Right drug
c) Right dose
d) Right time
e) Right route (including need for medication to be crushed)
f) Right reason
g) Right response
h) Right documentation."

Inspector #684 reviewed resident #002's medication orders and verified that the medications which were administered by RN #105 and RPN #106 were not prescribed for resident #002.

Inspector #684 interviewed the DOC who acknowledged that when administering medications the registered staff are to follow the 8 rights of medication administration. [s. 131. (1)]

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 or administered to 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): A medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

Inspector #684 reviewed a CI report which was submitted to the Director on a specified date in 2019, for a medication incident/adverse drug reaction for resident #002 that occurred 10 days earlier.

Inspector #684 reviewed the electronic progress notes for resident #002, and identified a progress note with the details of the incident. The Inspector noted the incident date to be a 10 days prior to when the CI report was submitted to the Director.

Inspector #684 reviewed the Medication incident -Original Report which showed the incident date and time.

Inspector #684 reviewed the home's policy "Critical Incident Reporting (ON), RC-09-01-06, last updated June 2019, as per policy "Inform the MOH Director no later than one business day after the occurrence of the incident of a medication incident or adverse drug reaction in respect of which a resident is taken to hospital."

Inspector #684 interviewed the Administrator regarding the medication incident which occurred on a specified day in 2019, and the CI report which was submitted to the Director was reviewed, specifically looking at the date the CI was submitted. Inspector #684 asked why it was reported 10 days late, the Administrator stated “the whole situation was very cloudy and upsetting, it was late reporting”. [s. 107. (3) 5.]

Issued on this 4th day of September, 2019

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

Original report signed by the inspector.