Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Aug 10, 2020	2020_548756_0012	013074-20, 013145-20, 013460-20	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 Laurier Manor
1715 Montreal Road GLOUCESTER ON K1J 6N4

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

LISA CUMMINGS (756)

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): July 6, 7, 8, 9, 10, 13, 2020.

Log #013460-20, log #013074-12, and a critical incident report (CI #2665-000033-20), all regarding a medication incident with a significant change in condition.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), a Registered Nurse (RN), and to several Registered Practical Nurses (RPNs).

During the course of the inspection, the inspector reviewed a resident health care record, observed the resident's room, observed services including medication administration, reviewed an internal investigation report, reviewed Medical Pharmacies policy #3-6 "The Medication Pass" revised January 2018, and reviewed Extendicare policies #RC-16-01-09 "Medication Incident and Reporting" revised February 2017 and #RC-16-01-11 "Medication Reconciliation" revised February 2017, and reviewed registered nursing staff education and orientation related to medication management systems.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
0 VPC(s)
1 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Licensee has a policy through their pharmacy provider, Medical Pharmacies, policy #3-6 “The Medication Pass”, revised February 2017. The policy is in line with the College of Nurses of Ontario (CNO) Medication Administration Practice Standards.

The policy indicates the following is to be done when conducting medication administration: Identify resident using two identifiers, such as photo, armband, or other staff, never by verbal response.

On a specified day, RPN #100 arrived at resident #001’s room which is shared with resident #002. The RPN went to resident #001 and administered resident #002’s 18 medications by mouth. Resident #001 does not have an order for these medications and they were administered in error.

As per RPN #100’s written statement, they went in the room, called out resident #002’s name and administered the medication to the resident who replied, which was resident #001. RPN #100 returned to the medication cart to confirm the medication administration and prepare resident #001’s medication when they realized they had administered the medication to the wrong resident.

The medication error was immediately reported to RN #102. The physician was immediately notified, resident #001’s health status was closely monitored, and then the resident was transferred to hospital for further assessment.

Through documentation in resident #001's healthcare record and when interviewed, both RN #102 and RPN #101, who were working the specified day, confirmed that RPN #100 administered resident #002’s medication to resident #001 in error. RPN #101 stated that resident #001 had their identification bracelet in place as well as their name and picture both in the medication cart and on the Medication Administration System (eMAR).

ADOC #103 stated that RPN #100 had not followed the licensee’s medication administration policy and practice standards when the RPN did not verify the resident’s identity prior to administering the medications. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

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 is used by or administered to a resident in the home unless unless the drug has been prescribed for the resident.

On a specified day, RPN #100 arrived at resident #001’s room, which is shared with resident #002. The RPN went to resident #001 and administered resident #002’s 18 medications. Resident #001 does not have an order for these medications and they were administered in error.

As per RPN #100's written statement, they went in the room, called out resident #002’s name and administered the medication to the resident who replied, which was resident #001. RPN #100 returned to the medication cart to confirm the medication administration when they realized they had administered the medication to the wrong resident.

The medication error was immediately reported to RN #102. Immediate nursing interventions were implemented, the physician was notified, resident #001’s health status was closely monitored, and then the resident was transferred to hospital for further assessment and intervention.

As such, on the specified day, resident #001 was administered 18 medications that were not prescribed for the resident. [s. 131. (1)]

Issued on this 27th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA CUMMINGS (756)
Inspection No. / No de l'inspection :	2020_548756_0012
Log No. / No de registre :	013074-20, 013145-20, 013460-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 10, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Laurier Manor 1715 Montreal Road, GLOUCESTER, ON, K1J-6N4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chris Smith

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s.8 (1) b.

Specifically, the licensee shall ensure that their policy through their pharmacy provider, Medical Pharmacies, policy #3-6 "The Medication Pass", revised February 2017, related to an interdisciplinary medication management system that provides safe medication administration is complied with.

To that effect, the licensee shall develop and implement monitoring and remedial processes as follows:

A) At a minimum, assess adherence to the section of policy #3-6, "The Medication Pass", that states two identifiers must be used to identify residents prior to administering prescribed medication. This shall be assessed at least on a weekly basis on all units.
B) Take immediate corrective action if deviations occur from established policy #3-6, "The Medication Pass", revised February 2017.
C) A written record must kept of everything required under (a) and (b).

Grounds / Motifs :

1. The licensee has failed to ensure that where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures that written policies and protocols are developed for the medication management system to ensure the accurate administration of all drugs used in the home and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Licensee has a policy through their pharmacy provider, Medical Pharmacies, policy #3-6, "The Medication Pass", revised February 2017. The policy is in line with the College of Nurses of Ontario (CNO) Medication Administration Practice Standards.

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Through documentation in resident #001's healthcare record and when interviewed, both RN #102 and RPN #101, who were working the specified day, confirmed that RPN #100 administered resident #002's medication to resident #001 in error. RPN #101 stated that resident #001 had their identification bracelet in place as well as their name and picture both in the medication cart and on the Medication Administration System (eMAR).

ADOC #103 stated that RPN #100 had not followed the licensee's medication

administration policy and practice standards when the RPN did not verify the resident's identity prior to administering the medications.

The severity of this issue caused actual harm to the resident. The scope was identified as an isolated incident. The home had a compliance history with ongoing non-compliance under the same subsection that included:

- written notification (WN) issued March 22, 2018 for s. 8(1)(b) (2018_627138_0002)
- WN issued October 22, 2018 for s. 8(1) (2018_617148_0028). (756)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 10th day of August, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Lisa Cummings

Service Area Office / Bureau régional de services : Ottawa Service Area Office