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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 20, 2016	2016_257518_0022	015345-16	Critical Incident System

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 LONDON
860 WATERLOO STREET LONDON ON N6A 3W6

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

ALISON FALKINGHAM (518)

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): May 25, 26, 27, 2016

This inspection was conducted as a result of log #105345-16 CIS 2173-000016-16 related to medication administration, log #3015365-16 CIS 2173-000017-16 related to medication administration and log #016159-16 CIS 2173-000018-16 related to medication administration.

During the course of the inspection, the inspector(s) spoke with the Director of Care, three Registered Staff members and four Personal Support Workers. The inspector reviewed three resident's clinical records, reviewed the home's policies and procedures, observed two medication administration passes on two nursing units and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Medication

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	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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident experienced a medical event.
The resident received new medical orders which specified the resident was to be sent to the hospital if signs and symptoms of a medical decline occurred. This information was available to the nursing staff in the physician orders and the twenty four hour nursing report.

The registered staff member found the resident to be in medical distress with a decline in the medical condition after the initial medical event. The registered staff member did not contact the physician, the family members or any other staff member and did not transfer the resident to the hospital.

Review of the resident's care plan, the physician orders, the twenty four hour nursing report and the emergency treatment record indicated that the resident was to be sent to the hospital if their medical condition deteriorated.

Review of the home's internal investigation indicated that the registered staff member was not aware of the changes in the plan of care and had not followed the most recent plan of care.

The DOC stated that the resident should have been transported to the hospital and that the care set out in the plan or care should be provided as specified. [s. 6. (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 the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A resident was given medications which were prescribed to another resident in error which resulted in a change in the resident's heath status.

Review of the home's internal investigation and interviews with the DOC and two registered staff members indicated that the registered staff member responsible for medication administration was called to the floor to help with the medication administration by the DOC and she was not familiar with the floor or the residents. The registered staff member stated she was interrupted by multiple other staff and residents and she acknowledged that she did not do the proper checks for safe medication administration.

Review of the home's internal investigation completed after the incident indicated the registered staff member had not followed the home's medication administration policy.

The Medical Pharmacies Policy and Procedure Manual Policy 3-6 The Medication Pass indicated:
"all medications administered are listed on the residents MAR, each resident receives the correct medication in the correct prescribed dosage at the correct time by the correct route
Procedure
1. Identify resident using two identifiers such as photo, armband, other staff, never by verbal response
3. find the MAR for the resident

4. locate the medications on the cart
5. check medication label against MAR to ensure accuracy"

The DOC said that the medication administration policy was not followed and verified the home's expectation was that all staff comply with the medication administration policy. [s. 8. (1) (b)]

2. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

A resident was given an incorrect dose of an ordered medication which resulted in a change in the resident's health status.

Review of the resident's clinical record, the homes internal investigation and interview with the DOC revealed that a registered staff member was ordered by the physician to give one milligram medication but due to the stressful situation she stated she gave one millilitre which is four times the ordered dose. The registered staff member noticed the error immediately and contacted the doctor by telephone.

Review of the home's internal investigation indicated the registered staff member had not followed the home's medication administration policy.

Review of The Medical Pharmacy Policy and Procedure Manual Policy 3-6 The Medication Pass indicates:
"all medications administered are listed on the residents MAR
-each resident receives the correct medication in the correct prescribed dosage at the correct time by the correct route
Procedure
1. Identify resident using two identifiers such as photo, armband, other staff, never by verbal response
3. find the MAR for the resident
4. locate the medications on the cart
5. check medication label against MAR to ensure accuracy"

The DOC said the medication error occurred and was reported immediately and that the home's expectation was that the policies and procedures regarding medication administration be complied with. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

Issued on this 20th day of July, 2016

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

Original report signed by the inspector.