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 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
Nov 29, 2018	2018_726724_0003	017591-18, 021100-18	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 Rouge Valley
551 Conlins Road TORONTO ON M1B 5S1

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

MIKO HAWKEN (724), ROMELA VILLASPIR (653)

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 29, 30, 31 and September 4, 2018.

During the inspection the following intakes had been inspected:

Critical Incident Log #(s):
017591-18 - related to an injury from an unknown cause.
021100-18 - related to a medication incident.

During the course of the inspection, the inspector(s) reviewed staffing schedules, clinical health records, the home's investigation notes and relevant home policies and procedures.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), Assistant Director of Care (ADOC), and the Director of Care (DOC).

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)**
- **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. 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 where the Act or Regulation required the licensee of a long-term care home have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system, is complied with.

According to O. Reg. 79/10, s.114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs are used in the home.

A review of the home's policy from Medical Pharmacies Pharmacy Policy and Procedures titled:
Emergency Starter Box - Policy 2-4 stated: A medication from the Emergency Starter box (ESB) is used when a new medication order is received from the prescriber, which required initiation of therapy prior to the next scheduled pharmacy delivery.

The Medication Pass - Policy 3-6 under "Procedure" stated: 6. a. Document on (e)MAR in proper space for each medication administered or document by code if medication not given.

A critical incident report (CIR) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time. The CIR report indicated resident #001 returned from hospital on a identified date and time with a prescription for medication to be given. The CIR further indicated on an identified date Registered Practical Nurse (RPN) #104 told the Substitute Decision Maker (SDM) the medication would not be available until the next pharmacy's scheduled delivery time. The CIR then stated the SDM suggested the medication be given to resident #001 at specific time because the

last dose given was given at a specific time while in the hospital. The SDM purchased the medication from an outside pharmacy, and gave it to RPN #104 who administered the medication to resident #001 at an approximate identified time.

The CIS further indicated that on a specific date resident #001 was noted be unwell and was sent to hospital for further assessment and returned to the home on a specific date. The home's investigation concluded RPN #104 had not followed the home's processes and policies by not utilizing the home's ESB for prescribed medications and not documenting when the medication had been administered to resident #001.

In an interview on an identified date with RPN #104, acknowledged that on an identified date the resident returned to the home from the hospital at specific time with an order for medication. RPN #104 indicated that they had contacted Registered Nurse (RN) #119 to see if the specific medication was available in the ESB, and was told by RN #119 that it was not and then gave the prescription to the SDM who purchased the medication from an outside pharmacy. RPN #104 also stated they administered medication to the resident between specific times. RPN #104 indicated they did not document the administration of the medication because they had forgotten to. RPN #104 further indicated that during this time RN #119 had called them back indicating that they had found the medication in the ESB.

A review of the eMAR for a specific month for resident #001 showed no documented signature for medication administered on identified date at approximately time made by RPN #104. The eMAR indicated a notation for a dose of the medication at identified date and time by RPN #114.

In an interview on identified date with RN #119 indicated that on identified date around a specific time they had received a call from RPN #104 to see if there was a specific medication in the ESM and had stated no without checking its contents. RN #119, indicated they then went to the ESM and found the medication and immediately called RPN #104 back to let them know they had found the medication. At this time RPN #104 indicated to RN #119 they had already sent the SDM to get the medication. RN #119 told RPN #104 to call the SDM to return to the home and to not accept the medication from the SDM as it was from an outside pharmacy.

In an interview with DOC #102 confirmed on identified date, RPN #104 failed to follow the home's medication policy related to the use of the ESB when a new medication is ordered as well as failing to document after administration the dose given between

specific times. With RPN #104's failure to document the administration of the medication given between specific times, resident #001 received an extra dose of the medication on a specific date and time. Therefore the licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was 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 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 is, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and
(b) has been provided by, or through an arrangement made by, the pharmacy service

provider or the Government of Ontario.

A critical incident report (CIR) was submitted to the Ministry of Health and Long Term Care (MOHLTC) on an identified date and time. The CIR report indicated resident #001 returned from hospital on an identified date and time with a prescription for medication to be given. The CIR further indicated on an identified date Registered Practical Nurse (RPN #104) told the Substitute Decision Maker (SDM) the medication would not be available until the next pharmacy's scheduled delivery. The CIR then stated the SDM suggested the medication be given to resident #001 at identified time because the last dose given was at an identified time while in the hospital. The SDM purchased the Medication from an outside pharmacy, and gave it to RPN #104 who administered the medication to resident #001 at an approximate time.

A review of the homes ESB Monitoring Form shows that the specific medication was available in the emergency box.

In an interview on an identified date with RPN #104, acknowledged that on an identified date the resident returned to the home from the hospital with an order for a specific medication. RPN #104 stated they had contacted Registered Nurse (RN) #119 to see if the specific medication was available in the ESB, and was told by RN #119 that it was not. The SDM was given the prescription for the medication and they left to retrieve it. RPN #104 further stated that they accepted the medication purchased by SDM and then administered the medication between specified times and failed to use the ESB stock of the specific medication available at the home.

In an interview on an identified date with RN #119 indicated that on an identified date and time they had received a call from RPN #104 to see if there was a specific medication in the ESM and had stated no without checking its contents. RN #119, indicated they then went to the ESM and found the specific medication and immediately called back RPN #104 to let them know they had found the medication in the ESB. At this time RPN #104 indicated to RN #119 that the SDM had already left get the medication from an outside pharmacy.

During an interview with ADOC #106 on an identified date acknowledged that RPN #104 had accepted the medication from the SDM and failed to utilize the available medication in the ESB supply or acquired the medication from the home's pharmacy provider.

In an interview with the DOC #102 on an identified date, acknowledged RPN #104 had

accepted the medication from the SDM and failed to utilize the ESB supply of medication available in the homes ESB.

Therefore, the licensee failed to ensure that a drug had been acquired, received or stored by or in the home or obtained for the purposes of the emergency drug supply, and had been provided by the homes pharmacy, or through an arrangement made by, the pharmacy service provider. [s. 122. (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 where the licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug, (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario is, to be implemented voluntarily.

Issued on this 3rd day of December, 2018

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

Original report signed by the inspector.