

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
Jul 5, 2019	2019_638542_0019	010798-19	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 Van Daele
39 Van Daele Street SAULT STE. MARIE ON P6B 4V3

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

JENNIFER LAURICELLA (542)

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 2 - 4, 2019.

The following intake was inspected;

One intake, related to medication administration.

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

The Inspector conducted daily observations of the provision of care, reviewed relevant health care records and policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication

Personal Support Services

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 were administered to residents in accordance with the directions for use specified by the prescriber.

A complaint was submitted to the Director, indicating that the home had not been administering two different medications to resident #001 since their admission to the home.

Inspector #542 completed a review of resident #001's health care record. On admission the registered staff completed the required document, titled, "Best Possible Medication History – Reconciliation/Admission Orders." It was documented on this record that resident #001 was to receive, one specific medication once a day and another medication, three times per day. On the Medication Administration Record it was documented that the one medication was not administered for 18 days and the other medication was not administered for 13 days.

Inspector interviewed RN #101, who indicated that resident #001 should not have gone without the two medications for as long as they did.

Inspector #542 interviewed RPN #102, who indicated that there was miscommunication regarding the coverage for the medications and that resident #001 went without the medications for a couple of weeks.

Inspector #542 interviewed the Assistant Director of Care (ADOC) who indicated that the home completed two medication incident reports as the home failed to provide the medications to resident #001. They further indicated that as a result of these incidents, the home revised their current practice and the registered staff were provided with re-education on medication reconciliation. [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.

Issued on this 5th day of July, 2019

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

Original report signed by the inspector.