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
May 21, 2019	2019_638542_0016	009765-19	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 Maple View of Sault Ste. Marie
650 Northern Avenue SAULT STE. MARIE ON P6B 4J3

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): May 14 - 15, 2019.

The following intake was inspected during this Critical Incident (CI) inspection;

A Critical Incident (CI) report related to a medication error.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), the resident and a family member.

The Inspector also conducted a tour of resident care areas, reviewed relevant health care records and the home's investigation records, related to the medication error.

The following Inspection Protocols were used during this inspection:
Medication

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	
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. 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 Critical Incident (CI) report was submitted to the Director, for a medication incident that altered resident #001's health status. It was described that, resident #001 was found to be experiencing various adverse symptoms. Upon further review of the residents' health care record, it was noted by the registered staff that the physician had written a new medication order and blood work order. The physician's order was to hold the medication for 72 hours, repeat blood work on a specific day, re-start the medication at a different dosage, by mouth, once daily, then repeat the blood work in one week and then every two weeks. The registered staff were unable to locate the results of the two blood work results and further noted that the resident was receiving the wrong dosage of the medication for a period of 8 days.

Inspector #542 reviewed resident #001's health care record. A review of the physician's order; verified the above information. The Medication Administration Record (MAR) was reviewed and it was documented that resident #001 received the wrong dosage of the medication over a period of eight days. The health care record did not include either of the 2 blood work results as ordered by the physician.

Inspector #542 interviewed the Director of Care (DOC) who indicated that RPN #100, originally reviewed the new order; however, they failed to ensure that a requisition was completed for the blood work, thus it was missed for the two times it was ordered by the physician. The order for the change in dosage of medication was also not processed correctly, a double check was not completed; therefore, resident #001 received the wrong dosage of medication for a period of 8 days. RPN #100 received re-education on medication administration, processing blood work orders and disciplinary action for the medication error and incorrect blood work processing.
[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 30th day of May, 2019

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

Original report signed by the inspector.