Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: January 27, 2023	
Inspection Number: 2022-1104-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Extendicare (Canada) Inc.	
Long Term Care Home and City: Extendicare Falconbridge, Sudbury	
Lead Inspector Amy Geauvreau (642)	**Inspector Digital Signature** Amy Geauvreau Digitally signed by Amy Geauvreau Date: 2023.02.13 13:52:49 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):

December 6-9, 12-14, 2022.

The following intake(s) were inspected:

- One Intake, related to the Medication Management system.
- Two Intakes: related to resident care concerns and concerns about a specific home policy.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Reporting and Complaints
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Medication Management System

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 123 (2).

The licensee has failed to comply with the Medication Management program.

Rationale and Summary

In accordance with O. Reg. 226/22, s 11 (1) (b), the licensee is required to ensure the home's Medication Management policies were complied with.

O. Reg. 226/22, s. 123. (2) requires the licensee to have written policies and protocols that are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

1. Specifically, staff did not comply with the home's "Drug Count" procedure, which was included in the home's policy "Management of Insulin, Narcotics and Controlled Drugs," which states that, "All narcotic waste will be witnessed by two nurses and the wastage recorded on the individual resident's Narcotic and Controlled Substances count sheet."

Interview with a Registered Practical Nurse (RPN) stated that they were asked by an RN to sign the medication wastage for residents. The RPN explained that per the procedure in the home, two nurses should be witnessing the drawing up of the medication dosage, and then also witnessing the wastage of the narcotic, and then signing off on the resident's Narcotic and Controlled Substances Count Sheet together.

a-b) On review of two residents' medication records, it was identified that the RN had documented they had provided the residents' their medication, and there was no second nurses signature on the records, for the administration and wastage of the medication.

c) Interview with another RPN who stated that the same RN had left for the day, and they were not there to witness the medication wastage for a specific resident so, the RPN had discarded it, and co-signed the wastage record, knowing that it was not the proper way. Further review of this resident's medication record identified the RN had administered this resident's medication and signed the record for other dates and there was no second nurse's signature on the record for the administration, and then there were different nurses who had signed for the wastage.

2. Staff did not comply with the home's Medication Management Policy procedure, which stated, to ensure that all residents have been given their medication and the documentation has been completed upon completion of the medication pass.

Review of the investigation notes, and interview with the Assistant Director of Care (ADOC), who had investigated the incident, also identified that the RN, had documented that they had given, specific residents' their medications.

Interview with the ADOC, identified, that when they interviewed these specific residents' about receiving their medications that day, they had all identified that they had not requested or received any medication's. The ADOC identified that the residents had no ill effects from the incident.

The Director of Care (DOC) identified the staff were not following the Medication Management policies, which were identified as: Management of Insulin, Narcotics and Controlled Drugs policy; and Medication Management Policy.

There was low minimal impact to the residents' health, safety, or quality of life.

Sources: CIS report; investigation notes; residents', Narcotic and Controlled Substances count sheets; Management of Insulin, Narcotics and Controlled Drugs policy; Medication Management policy; interviews with RPN's, ADOC, DOC, and other staff. [642]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 139 1.

The licensee has failed to ensure that all areas where drugs are stored shall be kept locked at all times.

Rationale and Summary

Intakes were submitted to the Ministry that identified a resident's medication had gone missing after they were placed in the medication room.

Review of the investigation notes identified that an Registered Practical Nurse (RPN) had placed this resident's medication in the medication room. The RPN had further stated in the notes, that they had left the medication room open and unattended.

Interview with the ADOC, stated that the medication door should always be locked, if a nurse is not in there.

This incident was a low impact, as no residents entered the medication room or were negatively affected.

Sources: Two intakes; investigations notes; policy titled, Security; door surveillance; interview's with PSW's; ADOC; and other staff. [642]

WRITTEN NOTIFICATION: Medical Cannabis

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 143 (1)

The licensee has failed to comply with the Long-Term Care home's (LTCH) Medical Cannabis policy.

Rationale and Summary

In accordance with O. Reg. 226/22, s. 11 (1) (b), the licensee is required to ensure the home's policies are complied with.

O. Reg. 246/22, s. 143. (1) requires every licensee of a long-term care home shall ensure that there are written policies and procedures to govern, with respect to residents, the Medical Cannabis policy.

Specifically, staff did not comply with the home's, Medical Cannabis policy.

The DOC and the Administrator explained that the staff had not been following their policy.

There was a minimal impact to the resident's health, safety, or quality of life.

Sources: Two intakes; a resident's progress notes; and the Medical Administration Report (MAR); investigation notes; email provided; the Medical Cannabis policy; interviews with the RN, ADOC DOC, Administrator, and other staff. [642]

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