

**Inspection Report under
the Long-Term Care
Homes Act, 2007****Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée****Long-Term Care Operations Division
Long-Term Care Inspections Branch****Division des opérations relatives aux
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
Oct 20, 2020	2020_505103_0017	007540-20, 014256- 20, 018837-20, 019237-20	Critical Incident System

Licensee/Titulaire de permisExtendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9**Long-Term Care Home/Foyer de soins de longue durée**Extendicare Kingston
309 Queen Mary Road KINGSTON ON K7M 6P4**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

DARLENE MURPHY (103)

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): October 7-9, 2020.

The following intakes were inspected:

Log #007540-20 (CIS #2616-000004-20), Log #014256-20 (CIS #2616-000006-20) and Log #019237-20 (CIS #2616-000008-20)-resident falls that resulted in an injury, and Log #018837-20 (CIS #2616-000007-20)- a medication incident.

During the course of the inspection, the inspector(s) spoke with residents, Registered Practical Nurses (RPN) and the Director of Care (DOC).

During the course of the inspection, the inspector made resident and resident room observations related to fall prevention measures, reviewed the critical incident system (CIS) reports submitted for each of the incidents, resident health care records including progress notes, post fall assessments, plans of care related the fall prevention, resident electronic medication records (eMAR) and physician orders.

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

<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 drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

The physician ordered a medication for a resident. Three days after the order, the resident had a change in condition which required additional treatment. During the home's investigation into the incident, they found the physician's order had been placed on hold by the pharmacy and flagged as pending confirmation. As a result, the order was not visible to the registered staff that were administering the resident's medication and the medication was not given as prescribed.

Sources: Resident progress notes, physician order, eMAR and interview with the DOC.
[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 drugs are administered to the resident as prescribed, to be implemented voluntarily.

Issued on this 26th day of October, 2020

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

Original report signed by the inspector.