

**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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**Public Copy/Copie du public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Nov 6, 2019	2019_565647_0025	018940-19	Critical Incident System

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**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.  
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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**Long-Term Care Home/Foyer de soins de longue durée**

Extendicare Kirkland Lake  
155 Government Road East KIRKLAND LAKE ON P2N 3P4

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

JENNIFER BROWN (647)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): October 30, 31, November 1, 2019.**

**The following intake was inspected upon during this Critical Incident System Inspection:**

**-one intake related to misappropriation of medication.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Practical Nurses (RPN), Provincial Constable from the Ontario Provincial Police, and residents.**

**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**

<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 Critical Incident System (CIS) report was submitted to the Director for a medication incident that affected residents #002, and #003. The CIS report indicated that on an identified date, the Administrator of the home had been notified by an identified staffing agency that Registered Practical Nurse (RPN) #104 had been found with packaged medication for the above-mentioned residents in RPN #104's possession.

A review of a report indicated, that medications were discovered not to be administered.

Inspector #647 completed a record review of the current physician's orders. The record review indicated that all of these residents had current physician orders to receive these medications, and should have received them as prescribed.

Inspector #647 reviewed the medication administration record (MAR) for these residents, for the corresponding dates of the located medications. The review identified that RPN #104 had documented that they had administered the medication to these residents.

During an interview with the Administrator, they confirmed to the Inspector, that the above medications had not been administered to resident's #002, or #003, as prescribed. [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 6th day of November, 2019**

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

**Original report signed by the inspector.**