Ontario

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 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 sions de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2016	2016_291194_0020	023678-16	Critical Incident System

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE PETERBOROUGH
80 ALEXANDER AVENUE PETERBOROUGH ON K9J 6B4

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

CHANTAL LAFRENIERE (194)

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): August 22, 23 and 24, 2016

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Clinical Coordinator (CC), Residents, Registered Practical Nurse (RPN), Registered Nurse (RN) and Office Manager.

The inspector reviewed clinical health records of identified residents, relevant policies, licensee internal investigation related to medication incident and observed medication administration.

The following Inspection Protocols were used during this inspection:
Medication
Pain

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Legendé 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. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions are taken in response to any medication incident involving a resident.

On an identified date RPN #103 received a medication shipment from the pharmacy. RPN #103 processed the shipment by scanning narcotics into the computer. The following day RN #109 noted the Narcotic blister pack for resident #008 had been tampered with. RN #109 indicated that two of the blisters had been popped out and put back with paper medical tape holding them in place. RN #109 administered resident #008's narcotic from a different blister on the narcotic card. SiX hours later, RN #109, #107 and RPN #106 inspected Resident #008's tampered narcotics. A new narcotic blister pack was ordered for resident #008. The narcotic blister pack and RN#109 and RN #107 statements were given to the Administrator four and half hours later. RPN #103 returned to work for a scheduled shift that day.

One hour after the shift began RPN #105 was asked to take over the medication cart from RPN #103. The following medication errors were noted to have occurred by RPN #103 during the one hour time frame on the identified date.
-Resident #008's - Narcotic card for identified time, had been split and the tampered with. Resident #008's additional narcotic for the same time frame had been signed as given at an identified time and was not available.

-Resident #009's Narcotic dose was signed as given at an identified time and was not available.

RPN #105 indicated that he/she gave resident #008's one of the narcotics ordered but did not administer the other because he/she was unable to get confirmation from the resident as to whether it had been given or not. RPN #105 indicated that he/she did not administer resident #009's narcotic because he/she was unable to get confirmation from the resident as to whether it had been given or not. A pain assessment was completed for both resident #008 and #009 with no increased pain noted.

An incident of narcotic tampering was noted on an identified date and time. RN statements and medication evidence was provided to management ten and half hours later. RPN #103 continued to administer medications to residents on the identified date, without additional interventions, increasing the potential risk of injury to residents.

This area of non compliance has been issued as a Compliance Order on September 01, 2016 under Inspection # 2016_293554_0017. [s. 134. (a)]

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.