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**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**

**Division de la responsabilisation et de la performance du système de santé**
**Direction de l'amélioration de la performance et de la conformité**

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 23, 2013 | 2013_196157_0018 | 000096/002 441 | Critical Incident System |

**Licensee/Titulaire de permis**

EXTENDICARE ~~CENTRAL ONTARIO ING~~ (CANADA) INC.
82 Park Road North, OSHAWA, ON, L1J-4L1

**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**

PATRICIA POWERS (157)

**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 15, 16, 17, 2013**

**The purpose of this inspection was to conduct an inspection of the following:**
**Log #002441-12**
**Log #000096-13**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Coordinator, 1 Registered Nurse, 2 Registered Practical Nurses, 1 resident.**

**During the course of the inspection, the inspector(s) reviewed the clinical health records of two identified residents, observed medication administration practices, reviewed facility policies related to medication administration/management, medication incident management and pain management, PRN medication administration.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**

**Medication**

**Pain**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend | Legendé |
| WN – Written Notification | WN – Avis écrit |
| VPC – Voluntary Plan of Correction | VPC – Plan de redressement volontaire |
| DR – Director Referral | DR – Aiguillage au directeur |
| CO – Compliance Order | CO – Ordre de conformité |
| WAO – Work and Activity Order | 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.)<br><br>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.<br><br>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. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,**
**(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).**
**(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).**
**(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).**

**Findings/Faits saillants :**

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1. Log #000096-13
Progress notes for resident #01 indicate that on an identified date, the resident experienced a medical condition due to a medication incident, which resulted in the need for assessment and treatment.
The licensee's documentation of a medication incident:
- did not indicate an analysis of the incident
- corrective action fails to provide a clear plan to prevent further risk to the resident.
- follow up action required to prevent further incidents of this nature states "Staff education on Med Administration Standards was completed October 30/31, 2012 - need refresher". There is no indication of planned/scheduled education to prevent further incidents.

There is no evidence that the incident was thoroughly reviewed and analyzed or that corrective action was taken to prevent the risk of harm to the resident.
Failure to review and analyze the incident and take adequate corrective action placed the resident at risk. [s. 135. (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 all medication incidents are reviewed and analyzed and corrective action taken as necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

1. Log #000096-13

The licensee's policy, "PRN Medications" dated September 2010 directs the following: "Each PRN order must state under what conditions the product is to be used"; "PRN orders must also contain the reason when the order may be followed or utilized. The reason for use should be documented on the MAR or TAR record"
PRN medication orders for resident #01 fail to identify under what circumstances the PRN medications are to be used.

The policy further directs the following:
"Approximately 30-60 minutes after administration of the PRN product the Registered Staff is responsible for completing and documenting a follow up assessment to determine the effectiveness of the product provided." Progress notes are to be used to document the effectiveness of the PRN given.
Documentation of administration of PRN medications for resident #01 fails to provide an evaluation of the effectiveness of the drugs administered. There is no evidence of the completion or documentation of a follow up assessment of effectiveness.

The policy further directs the following:
"Upon request from a resident for a PRN product or in follow up to a health concern expressed by a resident, Registered Staff will assess the resident based on the symptoms communicated to registered staff to determine the appropriate course of action which may include the administration of the PRN product"; "Progress notes are used to document the assessment prior to determining that a PRN product is required"
There is no documented evidence of assessment of resident #01 prior to determining that a PRN medication is required or to identify the reason for the administration of the medication. [s. 8. (1)]

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs**
**Every licensee of a long-term care home shall ensure that,**
**(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and**
**(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.**

**Findings/Faits saillants :**

1. The plan of care for resident #01 failed to accurately reflect a physician's medications orders.
The licensee failed to ensure that orders for the administration of a drug to a resident are reviewed when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care. [s. 117. (a)]

**WN #4: 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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).**

**Findings/Faits saillants :**

1. Log #002441-12
On an identified date, an unregulated care provider was witnessed to have administered a drug to a resident.
The licensee failed to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or registered practical nurse. [s. 131. (3)]

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**Issued on this 25th day of October, 2013**

| Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs |
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| Pat Rivers #157 |