Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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
Inspection de 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
Feb 20, 2020	2020_786744_0004	023214-19, 000984-20, 002216-20	Complaint

Licensee/Titulaire de permis

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

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

Extendicare Timmins
62 St-Jean Avenue TIMMINS ON P4R 0A6

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

STEVEN NACCARATO (744), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 10-14, 2020.

The following intakes were inspected upon during this Complaint inspection:
-Two complaint logs regarding staffing shortages and care concerns;
-One complaint log regarding wound care and safe transferring techniques.

Critical Incident System (CIS) inspection #2020_786744_0005 was conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The Inspectors also observed resident care areas, the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, complaint records, and policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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. 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 complaint was submitted to the Director, which indicated that resident #001 had not received proper care.

Inspector #744 reviewed resident #001's electronic health care records and identified under the Physician's Orders, a specified order which had been prescribed for resident #001 since a specified date.

A) Inspector #744 reviewed resident #001's electronic health care records and identified a note from a specified date which indicated that resident #001 had not received a correct dose of an ordered medication.

In an interview with Inspector #744, RPN #104 indicated that resident #001 required a specified order, but the order was not given correctly on a specified date.

B) Inspector #744 reviewed resident #001's electronic health care records and identified a note from another specified date which indicated that resident #001 had not received a correct dose of an ordered medication.

In an interview with Inspector #744, RPN #112 indicated that they had observed that resident #001 received an incorrect dose of a specified order.

Inspector #744 interviewed the Director of Care (DOC) who confirmed that resident #001 had a specified order; however, this specified order was not followed in accordance with the directions for use specified by the prescriber. [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.

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. The licensee has failed to ensure that, where Ontario Regulation (O.Reg.) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols 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.

Specifically, staff did not comply with the licensee's policy titled "Medication Incident and Reporting" last updated February 2017. The policy identified that the medication incident report was used to report all medication incidents that occurred or were discovered in the home.

A complaint was submitted to the Director, which indicated that resident #001 had not received proper care.

A) Inspector #744 reviewed resident #001's electronic health care records and identified a note from a specified date which indicated that resident #001 had not received a correct dose of an ordered medication

In an interview with Inspector #744, RPN #104 indicated that they had discovered the medication incident and reported it to the RN; however, they did not complete a

medication incident report. RPN #104 further stated that they should have ensured a medication incident report was completed through the home's electronic reporting system.

B) Inspector #744 reviewed resident #001's electronic health care records and identified a note from a specified date which indicated that resident #001 had not received a correct dose of an ordered medication.

In an interview with Inspector #744, RPN #112 indicated that they should have completed a medication incident report on the home's electronic reporting system upon discovery of the medication incident; however, they were unsure about the reporting process at the time of the incident.

Inspector #744 interviewed the DOC who indicated that staff were expected to report medication incidents to the home such as residents receiving extra doses of medication and dose omission. The DOC further indicated that reported medication incidents were investigated by management and improvements to medication administration were recommended. Inspector #744 and the DOC reviewed the Medication Incident reports submitted for specified dates; however, there were no medication incidents reports concerning resident #001 submitted. The DOC confirmed that staff should have followed the home's medication incident reporting policy. [s. 8. (1) (b)]

Issued on this 20th day of February, 2020

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

Original report signed by the inspector.