

**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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<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>
Sep 13, 2019	2019_648741_0019	012744-19, 015804-19	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 London  
860 Waterloo Street LONDON ON N6A 3W6

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

AYESHA SARATHY (741)

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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): September 3-6, 2019**

**During the course of this inspection, the following Critical Incidents (CI) were inspected.**

**CI #2173-000017-2019 related to an allegation of physical abuse from staff to resident**

**CI #2173-000023-2019 related to a medication incident**

**During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), the Wound Care Champion, the Director of Care (DOC) and a resident. The inspector also observed residents and reviewed relevant policies and procedures, medication incident reports, and clinical records for identified residents.**

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

**Medication**

**Prevention of Abuse, Neglect and Retaliation**

**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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

A Critical Incident was submitted to the Ministry of Long-Term Care (MOLTC), related to a medication incident where the medications of a resident were administered to another resident in error.

The CI report and Medication Incident Report were reviewed, and stated that the error occurred due to a Registered Practical Nurse (RPN) relying on the direction of another staff member to identify the resident. The resident who received the wrong medications was sent to the hospital as a precautionary measure following the medication error, and it was reported that the error did not result in any adverse reactions to the resident.

The home's policy titled "Medication Management", last updated February 2018, was reviewed, and stated that prior to administering drugs, nurses are required to use two resident identifiers and follow the eight rights of Medication Administration.

In an interview, the RPN who administered the wrong medications said that they were aware of the home's policy for medication administration but did not follow it on the day of the medication incident, resulting in the medication error. In another interview, the Director of Care (DOC) also verified that wrong medications were administered to the identified resident.

The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (1)]

***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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.***

**Issued on this 13th day of September, 2019**

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

**Original report signed by the inspector.**