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 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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2019	2019_520622_0008	010623-18, 020225-18, 023260-18, 030244-18	Critical Incident System

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 Cobourg
130 New Densmore Road COBOURG ON K9A 5W2

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

HEATH HEFFERNAN (622), CATHI KERR (641)

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): May 6, 7, 8, 9, 10, 2019

The following logs were completed during this inspection:

Log #020225-18/Critical Incident System report (CIS) #2851-000019-19 and Log #023260-18/Critical Incident System report (CIS) #2851-000022-18 related to missing/unaccounted for controlled substance.

Log #010623-18/Critical Incident System report (CIS) #2851-000014-18 related to disease outbreak

Log #030244-18/Critical Incident System report (CIS) #2851-000030-18 related to a fall of a resident causing injury for which the resident was taken to hospital and which results in a significant change in the resident's health status.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Quality Improvement Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN), and Personal Support Workers (PSW).

Also during the course of the inspection, the inspectors reviewed health records, the applicable Critical Incident System reports(CIS), the licensee's investigation documents, Narcotic and Controlled drug counts, the Medical Pharmacies policies titled; Medication Administration Record # 8-1, Medication Incident Reporting # 9-1, Storage of Monitored medications #6-4, Shift Change Monitored Drug Count #6-6, the Licensee's policies titled; Medication Incident and Reporting #RC-16-01-09, Management of Narcotic and Controlled Drugs #RC-16-01-13, observed narcotic and controlled drug storage.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Infection Prevention and Control
Medication

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. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

Critical Incident System report (CIS) #2851-000022-18 dated a specified date indicated that a PRN controlled substance for resident #001 was noted missing during the shift to shift change count that date.

On May 6, 2019, inspector #622 reviewed the homes incident investigation file which included a hand written document titled; Missing Controlled Substance. The document stated that on a specified date at a specified time prior to the shift to shift change count when resident #001's controlled substance was noted missing, RN #102 was observed to have left the medication room open, the keys were on the medication cart and the cart was unlocked.

During an interview with inspector #622 on May 7, 2019, the Director of Care (DOC) #100 stated that they had completed the hand written document titled; Missing Controlled Substance. DOC #100 stated that on the specified date and time, they went to the nursing office and noted that the medication room door was left open, the keys were left on top of the medication cart and the cart was unlocked. DOC #100 stated that they waited for RN #102 to return to the medication room where they were educated. DOC #100 indicated that on the specified date and time, the medications had not been kept secure and locked. [s. 129. (1) (a)]

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 that drugs are stored in an area or a medication cart that is secure and locked,, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee of a long-term care home shall ensure that the Director is immediately informed of an outbreak in the home of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

Critical Incident #2851-000014-18 was submitted to the Director on a specified date. The critical incident (CIS) documented that four residents on one unit were identified with upper respiratory symptoms starting ten days prior. An acute respiratory illness (ARI) outbreak was declared by the Public Health Unit six days prior to the submission of the critical incident.

During an interview with Inspector #641 on May 9, 2019, the Director of Care (DOC) advised that on the day an outbreak was declared in the home, a CIS would be submitted to the Director. When asked by the Inspector why the CIS for this outbreak was not submitted until six days after the outbreak was declared, the DOC reviewed the calendar for that time frame and advised being on holiday then. When asked if there was anyone else in the home who would initiate a CIS when the DOC wasn't available, the DOC advised that there was and they now had another manager available to submit critical incidents when necessary.

The licensee failed to ensure that the Director was informed immediately when an outbreak of a reportable or communicable disease was declared in the home on a specified date. [s. 107. (1)]

Issued on this 24th day of May, 2019

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

Original report signed by the inspector.