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 soins 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
May 24, 2017	2017_639607_0008	004095-17	Follow up

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 OSHAWA
82 PARK ROAD NORTH OSHAWA ON L1J 4L1

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

JULIET MANDERSON-GRAY (607)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 11, 12, 15, 16, 17, and 18, 2017

During this follow up inspection the following intakes were inspected: Logs # 004095-17 and 035437-16.

Summary of Intakes:
1) 004095-17: A follow up to a Compliance Order, regarding Medication Administration policy not being complied with.
2) 035437-16: A Critical Incident Report (CIR), regarding missing or unaccounted for controlled substance that was completed concurrently with the follow up to the order.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), a Substitute Decision Maker (SDM) and a Resident.

During the course of the inspection, the Inspector reviewed clinical health records, observed staff during medication administrations, reviewed training records, medication incidents, audit records and evaluation of Medication process, home specific policies related Leave of Absence Medications, Medication Incidents and Reporting and Medication Management.

The following Inspection Protocols were used during this inspection:
Medication

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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 8. (1)	CO #001	2016_328571_0033	607

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. 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 their Leave of Absence Medications policy #RC-06-05-23 was complied with specifically related to resident #008.

O. Reg. 79/10, r. 128 requires the licensee to ensure that a policy is developed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director, to govern the sending of a drug that has been prescribed for a resident with him or her when he or she leaves the home on a temporary basis or is discharged.

Related to Intake Log #035437-16 involving resident #008:

A Critical Incident Report (CIR) was submitted to the Director on an identified date, for an incident related missing or unaccounted for controlled substance that occurred on a specified date and time. The CIR indicated that resident #008 was sent on a leave of absence (LOA) with family and with control substances. The resident returned with several missing control substances; had a change in condition, and was transferred to hospital.

A review of the licensees "Leave of Absence Medications policy #RC-06-05-23 dated January 2017, directs:

a) Leave with Medication Form – used to document what medications are released, as well as, quantity of medication. The form is to include administration instructions and

special instructions related to the medications.

b) MAR/EMAR – The appropriate code on the Medication Administration Record (MAR) or Electronic Medication Administration Record (EMAR) is to be used to indicate the resident's absence from the home.

c) Progress notes – used to document the leave for the resident and all actions taken in preparation for the leave. Notes should indicated name and contact person who has taken the resident from the home

d) Drug record book – used to reconcile receipt of medication orders.

Procedures:

Unplanned Leave of Absence (LOA) – Narcotics and Controlled Drugs:

1) For spontaneous LOA requiring narcotics and controlled drugs, two nurses will sign out the residents entire medications supply if it is required for the residents LOA, and provide it to the resident and or responsible party;
2) On the residents return, two nurses will count the LOA narcotic medication and controlled drug of the Residents;
3) Upon return of the narcotic medications and controlled drugs from the LOA, the Nurse will assess to ensure the return portion has not been tampered with, and the blister packs are intact, as per Management of Narcotics and Controlled Drugs policy
4) The unused portion of the unplanned LOA narcotic and controlled drug medication will be placed for further use;
5) The resident or family SDM is to sign the Leave with Medication Form;
6) During the period of absence, registered nursing staff will record the appropriate code on the MAR, that indicates the resident is absent from the home with medications

A review of the Leave with Medication Form for resident #008, with a specified date, at an identified time, by the Inspector, indicated the resident went out on LOA accompanied by a family member and had several medications signed out as being released, including controlled substances.

Further review of the Leave with Medication Form for resident #008, indicated there was only one signature of a registered staff member, indicating the release of the medications to the resident's family member. In addition, the individual Narcotic Monitored Medication

Record failed to locate a signature of the staff who signed out the release of medications or signed in medications upon the resident return from LOA.

Interview with RPN #102 indicated to the Inspector that he/she had signed out the medications for resident #008 with another RPN and indicated he/she thought there were two signatures identified on the Leave with Medication Form.

Interview with the ADOC and DOC, by the Inspector, both indicated that it is the home's expectation that two staff are to sign for control substances when residents are leaving with medications for LOA and upon return.

The Licensee failed to ensure it's Leave of Absence Medications policy #RC-06-05-23 was complied with, specifically related to procedures one and two: 1) For spontaneous LOA requiring narcotics and controlled drugs, two nurses will sign out the residents entire medications supply if it is required for the residents LOA, and provide it to the resident and or responsible party; 2) On the residents return, two nurses will count the LOA narcotic medication and controlled drug of the residents, specifically related to resident #008. [s. 8. (1) (b)]

2. The licensee has failed to ensure their Medical Pharmacy Ordering and Receiving Medication policy #4-11 was complied with, specifically related to resident #008.

O. Reg. 79/10, r. 114. (2), requires the licensee to ensure that written policies and protocols are 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.

Related to Intake Log #035437-16 involving resident #008:

A review of the home's Medical Pharmacy Ordering and Receiving Medication policy #4-11 directs:

When the shipment is ordered it is the responsibility of the nurse to document all orders received according to procedure. At this time all narcotics medications should be entered into a facility specific recording form.

A review of resident #008's Individual Monitored Medication Record indicated the home received several control substance medications on an identified date on behalf of the

Licensee.

Further review of the Monitored Medication Record failed to identify signatures of the persons who received or witnessed the receipt of the above identified medications on behalf of the Licensee.

Interview with the DOC indicated the expectation is two Registered staff are to sign the receipt of any narcotics received by the home on behalf of the Licensee.

The licensee failed to ensure their Medical Pharmacy Ordering and Receiving Medication policy #4-11 was complied with, specifically related to resident #008, and the Monitoring Medication Record not identifying the signature of a person who received or witnessed the receipt of narcotics medications on behalf of the Licensee. [s. 8. (1) (b)]

Issued on this 26th day of May, 2017

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

Original report signed by the inspector.