



**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**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 17, 2013	2013_198117_0007	O-000106- 13, O- 000231-13	Critical Incident System

Licensee/Titulaire de permis

**EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2**

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

**EXTENDICARE STARWOOD
114 STARWOOD ROAD, NEPEAN, ON, K2G-3N5**

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

LYNE DUCHESNE (117)

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): on April 15 and 16, 2013, on site at the Long-Term Care Home

It is noted that 2 Critical incident inspections were conducted during this inspection : Log # O-000106-13 and Log # O-000213-13

31 LD - Apr 18 13.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Assistant Director of Care, Clinical Care Coordinator, a Registered Nurse (RN), several Registered Practical Nurses (RPN), several Personal Support Workers and to several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several identified residents; observed resident care and services; reviewed several Critical Incident Reports.

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

Medication

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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



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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. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :



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1. The licensee failed to comply with O.Reg 79/10 s. 134 (a) in that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there was no monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Resident #3 is known to have responsive behaviours. Resident #3 has medical orders for a psychotropic medication to be given twice daily, as needed (prn), when the resident is agitated. On a specified day in March 2013, Medication Administration Records (MAR) as well as progress notes document that Resident #3 received the prescribed psychotropic prn medication in early evening. The MAR and progress notes also indicate that Resident #3 also received their regularly prescribed psychotropic medication 3 hours later. There is no documentation as to the reason why the psychotropic prn medication was administered nor its effect on the resident's behaviours. As well, there is no documentation as to the resident's response after the administration of the night time psychotropic medication, this a few hours after the administration of the prn medication.

On April 16, 2013, interviewed unit registered staff stated to the Inspector that the home's policy is to document the reasons why a prn medication is given as well as its effectiveness. The home's DOC confirmed the home's medication administration documentation practices related to prn medication. The DOC also stated that it was an agency RPN who was working on the identified day in March 2013. The DOC and the home's Administrator confirmed that the agency RPN had received orientation and training regarding the home's medication documentation practices. [s. 134. (a)]



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Issued on this 17th day of April, 2013

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

Lyne Duchesne #117