Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central West Service Area Office
609 Kumpf Drive, Suite 105
Waterloo ON N2V 1K8
Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

Original Public Report

Report Issue Date August 25, 2022
Inspection Number 2022-1211-0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
488491 Ontario Incorporated

Long-Term Care Home and City
Avalon Retirement Centre, Orangeville

Lead Inspector
Janet Groux #606

Additional Inspector(s)

Inspector Digital Signature
Janet Groux Digitally signed by Janet Groux Date: 2022.09.01 15:18:19 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): July 26-29, and August 3-5, 2022.

The following intakes were inspected:

- Intake #011919-22 regarding the breakdown of an air conditioning unit;
- Intake #001637-22 regarding missing narcotic medications;
- Intake #000907-22 regarding a resident's fall resulting in a serious injury; and
- Intake #017274-21, regarding a resident to resident altercation.

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

- Falls Prevention and Management
- Housekeeping, Laundry and Maintenance Services
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Responsive Behaviours
- Staffing, Training and Care Standards

INSPECTION RESULTS

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WRITTEN NOTIFICATION: MEDICATION MANAGEMENT SYSTEM

NC#1 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 79/10 s. 114(2)

The licensee failed to comply with the policies and protocols developed to ensure the adequate dispensing, storage, and administration of a resident's medication.

In accordance with O. Reg. 79/10 s. 8(1)(b) the licensee is required to ensure that there is a 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 home's Narcotics and Controlled Substances policy, which is captured in their medication management system.

Rationale and Summary

A Critical Incident System (CIS) reported missing narcotic medications.

The home's narcotics and controlled substances policy stated that the off going and on coming Registered staff members at change of shift, and whenever an exchange of medication keys takes place, must complete the count together and must be signed by both registered staff members.

During a shift narcotic count between two registered staff, the registered staff identified the count for a resident's narcotic medication was incorrect and was missing a number of tablets.

The controlled substance shift count record for the Resident Home Area (RHA) was incomplete and was missing one of the signatures from the two registered staff who completed the count from the previous shift.

Two registered staff said that at the end of every shift, a narcotic count was completed by the registered staff going off shift and the registered staff coming on shift. The two registered staff must sign the narcotic count sheet after the count.

Failure to follow the home's policy may have contributed to the incident and put a resident and other residents' at risk.

Sources:
A critical incident report, the home's controlled substance shift, the home's Narcotics and Controlled Substances policy, a resident's MAR and interviews with staff. (606)

WRITTEN NOTIFICATION: TRAINING AND ORIENTATION

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NC#2 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007 s. 76(2)(10)

The licensee has failed to ensure orientation that was relevant to a registered staff's responsibilities, was provided to a registered staff prior to being assigned to a resident home area (RHA).

Rationale and Summary

A CIS reported a medication incident regarding missing narcotic medications.

A registered staff's orientation record was incomplete and did not identify that the registered staff received orientation on the home's policy on narcotic shift count.

The registered staff said they were assigned to a RHA to administer medications to the residents and to make sure the residents were provided care properly and ensure their safety.

The registered staff said they did not recall the home providing them orientation on the home's policies and procedures, specifically, the home's policy on shift narcotic count.

The DOC acknowledged that registered staff were expected to receive orientation and training on the home's medication management system and this would have included the home's policy on completing a narcotic count every shift.

Failure to provide a registered staff orientation may have been a factor that contributed to the medication incident and may have put a resident and other residents at potential risk of harm.

Sources:
A registered staff's orientation checklist, and interviews with staff. (606)