Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux 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
Jan 5, 2022	2021_911506_0009	010512-21, 016056-21, 018425-21	Critical Incident System

Licensee/Titulaire de permis

Dover Cliffs Operating Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Dover Cliffs
501 St. George Street P.O. BOX 430 Port Dover ON N0A 1N0

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

LESLEY EDWARDS (506)

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): December 8, 9, 10, 14, 15 and 17, 2021

This inspection was completed related to the following Critical Incident System (CIS) intakes:

Log #010512-21- for medication management
Log #016056-21- for fall prevention and management; and
Log #018425-21- for unexpected death.

This inspection was conducted concurrently with complaint inspection #2021_911506_0010.

During the course of the inspection, the inspector(s) spoke with Executive Director, Associate Director of Care (ADOC), Infection Control Lead, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers, Environmental Service Manager (ESM), housekeeping staff, Nurse Practitioner (NP), Recreation Manager and residents.

During the course of the inspection the inspector toured the home, completed an infection prevention and control assessment (IPAC) checklist, observed dining and snack services, medication administration, reviewed clinical records, policies and procedures, video surveillance, investigation notes, observed the provision of care and conducted interviews.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Personal Support Services

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 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. 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 :

The licensee failed to ensure that where the Act and Regulation required the licensee of a long term care home to have, institute or otherwise put in place any policy, the policy was complied with.

In accordance with S. O. 2007, s. 8 (1) , and in reference to O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies developed for the medication management system to ensure accurate storage, administration and disposal of all drugs used in the home.

Specifically registered staff did not comply with the licensee's policy titled: "Narcotic and Controlled Medication and Cannabis Counting Process", which stated: "Two staff (leaving and arriving), together.

On a specified date in July 2021, the home identified a missing controlled substance.
Video surveillance footage confirmed that the incoming nurse completed the shift count by themselves.
The staff member confirmed that they did not complete the shift count with the oncoming nurse as per the home's policy.

Sources: CIS, video footage surveillance, policy "Narcotic and Controlled Medication and Cannabis Counting Process", interview with ADOC and other staff. [s. 8. (1) (b)]

WN #2: 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 :

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

On a specified date in July 2021, the home identified a missing controlled substance.
Video surveillance footage indicated that the missing controlled substance was stored on top of the medication cart and not in a separate locked area.
During change of shift the staff member identified that the controlled substance was missing.
The ADOC confirmed that the controlled substance was not stored in a separate locked area within the locked medication cart.

Sources: CIS, video surveillance footage and interview with the ADOC. [s. 129. (1) (b)]

Issued on this 6th day of January, 2022

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

Original report signed by the inspector.