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
Jul 28, 2016	2016_483637_0010	019801-16	Resident Quality Inspection

Licensee/Titulaire de permis

The Board of Management for the District of Parry Sound East
62 Big Bend Avenue Box 400 POWASSAN ON P0H 1Z0

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

EASTHOLME HOME FOR THE AGED
62 BIG BEND AVENUE P.O. BOX 400 POWASSAN ON P0H 1Z0

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

MISHA BALCIUNAS (637), ADAM DICKEY (643), AMY GEAUVREAU (642), CHARLES SMITH (635), DEREGE GEDA (645), LYNE DUCHESNE (117), MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): July 11-15, and July 18-22, 2016.

The following were also inspected concurrently:
A critical incident report related to a resident fall.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing and Personal Care (DOC), the Co-ordinator of Resident Services, the Director of Recreation and Therapy Services, the Nursing Administrative Assistant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Dietary Aide, Orderly, residents and residents' family members.

During the course of the inspection, the inspector(s) directly observed the delivery of care, and services to residents, resident to resident interactions, conducted a tour of resident home areas, reviewed resident health care records, reviewed polices, various procedures and programs within the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Residents' Council
Responsive Behaviours
Skin and Wound Care

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)

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. 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 were stored in an area or a medication cart that was secured and locked.

On July 20, 2016, Inspector #637 observed an unlocked medication cart outside a specific area within the home, with the bottom drawer partially open, and the key in the medication cart. Inspector #637 observed that a specific Registered Practical Nurse (RPN) was out of sight of the medication cart and no staff were around the cart.

The specific RPN confirmed that the medication cart was unlocked, the key was in the cart, and that they were not in sight of the medication cart. The specific stated that the homes expectation was that the medication cart was to be locked, whenever the registered staff was not in direct view of the cart. The specific RPN confirmed that the cart should have been locked and the keys removed.

A review of the home's medication policy titled, "Safe Drug Storage, Section 15," last reviewed March 2016, revealed that the medication storage area must be locked when not in use and should be accessible only to authorized personnel.

On July 21, 2016, Inspector #642 interviewed the DOC who verified that it was the

licensee expectation that the medication cart should be locked at all times when unattended. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and double locked.

On July 20, 2016, Inspector #637 observed an unlocked medication cart outside the second floor south dining area, with the bottom drawer partially open, and the key in the medication cart. Inspector #637 observed that a specific RPN was out of sight of the medication cart and no staff were around the cart.

The specific RPN confirmed that the medication cart was unlocked, the key was in the cart, and that they were not in sight of the medication cart. The specific RPN stated that the homes expectation was that the medication cart was to be locked, whenever the registered staff was not in direct view of the cart. The specific RPN confirmed that the cart should have been locked and the keys removed.

A review of the home's medication policy titled, "Safe Drug Storage, Section 15," last reviewed March 2016, revealed the medication storage area must be locked when not in use and narcotic and controlled substances should be always be stored in a separate locked area in the medication cart.

On July 21, 2016 Inspector #642 interviewed the DOC who verified that it was the homes' expectation that the medication cart should be locked at all times when unattended. [s. 129. (1) (b)]

Issued on this 29th day of July, 2016

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

Original report signed by the inspector.