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 prévue 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 15, 2018	2018_749722_0001 (A1)	005352-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Lakefield
19 Fraser Street LAKEFIELD ON K0L 2H0

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This Licensee Report for the Resident Quality Inspection at Extendicare Lakefield that started on June 11, 2018, was amended by Inspector #722 for the following corrections:
- RN #019 was revised to RN #119 for non-compliances issues under the LTCHA, 2007 s. 6.(11)(b) and s.8.(1)(b);
- RPN #016 was revised to RPN #106 for non-compliances issued under the LTCHA, 2007 s. 8.(1)(b).

These revisions accurately reflect the staff members who were considered in the evidence for these non-compliances.

Issued on this 15th day of November, 2018 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11, 12, 13, 14, 18, 19, 20, 21, 22, 25, 26, 27, 28, and 29, 2018

The following intakes were inspected concurrently during this inspection:

Complaints:

Log #004922-18 related to resident care

Log #026216-17 related to resident care and alleged abuse

Critical incidents:

Log #023977-17 related to resident to resident abuse

Log #024474-17 related to resident to resident abuse

Log #024062-17 related to resident to resident abuse

Log #024417-17 related to resident to resident abuse

Log #027152-17 related to resident to resident abuse

Log #004055-18 related to falls

Log #025886-17 related to falls

Log #000310-18 related to medications

Log #008715-17 related to medications

Log #010528-18 related to medications

Log #028083-17 related to medications

Log #029490-17 related to medications

Log #007304-18 related to medications

Inspector #111 was also present each day of the inspection as a Certified Trainer while adhering Inspector #722.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Coordinator (CC), Resident Program Manager (RPM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dieticians (RDs), Personal Support Workers (PSWs), Nursing Aides (NAs), residents and substitute decision makers (SDMs).

During the course of the inspection, the inspectors conducted a tour of the home; observed infection prevention and control practices, dining activities, medication administration, staff to resident and resident to resident interactions, and resident home areas; and reviewed clinical health records (electronic and hard copy), staff schedules, and relevant home policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

4 WN(s)
3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

(A1)
1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.

During Stage 1 of the Resident Quality Inspection (RQI), resident #003 was interviewed by inspector #722 and indicated that staff assist with oral care once a day in the evening and that they would like assistance more frequently. The written plan of care for resident #003 was unclear in terms of the resident's oral hygiene requirements, resulting in inconsistent provision of oral care by staff in the home.

The most recent RAI-MDS assessment indicated that resident #003 required extensive assistance with oral hygiene.

The current written care plan for resident #003 was reviewed related to oral health and hygiene, which indicated that staff will assist resident to brush hair, brush teeth, and wash face. The current care plan did not specifically describe what oral

care was to be provided to the resident, including the frequency and level of assistance required.

During separate interviews with PSW #104 and PSW #122 by inspector #722 during this inspection, both PSWs indicated that care needs for residents in the home could be found on a Kardex. Review of resident #003's current Kardex by Inspector #722 did not specify the resident's oral hygiene requirements specific to their dentition and/or oral health needs.

During separate interviews with PSW #104 and PSW #122 by inspector #722 during this inspection, both indicated that all resident care is documented in Point-of-Care (POC). POC documentation was reviewed for a specified date and there was no documentation by PSWs indicating specifically that oral care was provided to resident #003. General entries were made indicating that care had been provided on all three shifts; however, it was not clear if oral care was part of this care.

Resident #003 was interviewed by inspector #722 during this inspection related to oral care. The resident indicated that they are able to perform some of their own oral care with assistance. The resident also indicated that they would like additional assistance with oral care, but indicated that they have not notified staff in the home about their oral care preferences.

Inspector #722 interviewed PSW #104 during the inspection, related to resident #003's oral care. PSW #104 described the resident's dentition, and indicated that resident #003 receives assistance from staff for oral care. PSW #104 indicated that the staff provided assistance by setting up resident #003 for morning hygiene, including oral care, but that they do not stay in the room while the resident performs morning care. PSW #104 indicated that resident #003 has never informed them that they would like more assistance with oral care.

Inspector #722 interviewed PSW #122 during the inspection related to resident #003's oral care. PSW #122 described resident #003's dentition (which differed from PSW #104's description), and described assistance provided by staff for oral care. PSW #104 indicated that the resident performs their own oral care independently, including setting up.

The licensee has failed to ensure that there is a written plan of care related to oral hygiene for resident #003 that set out clear directions to staff and others who

provide direct care to the resident, as the written care plan did not specify oral care requirements related to the resident's own specific oral health care needs. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During Stage 1 of the RQI, a census record review was completed for resident #004 and a significant weight loss was identified. The measured weights for resident #004 documented in the electronic health record for the past six months were reviewed and indicated that resident #004 had consistent monthly weight loss during this period, with a significant weight loss over an identified period.

The current written care plan for resident #004 related to nutrition/hydration was reviewed and indicated under nutritional problem: poor to fair food and fluid intake and significant weight loss. A nutritional supplement with meals was one of the interventions identified on the care plan as an intervention to prevent further weight loss.

The progress notes for resident #004 for an identified period, related to nutrition and weight loss, indicated the following:
- On a specified date, Registered Dietician (RD) #115 identified fair intake and weight loss and recommended adding a nutritional supplement.
- On another specified date, RD #115 identified a significant weight loss in an identified period of time and that resident #004 was at nutrition risk due to poor to fair food and fluid intake; RD #115 recommended increasing the amount of nutritional supplement.

The Physician Orders for resident #004 were reviewed and indicated that RD #115 ordered a specific amount of nutritional supplement on a specified date; increased the amount of supplement on a later specified date; and on another specified date, re-ordered the same amount of nutritional supplement that was originally ordered.

The resident's health record was reviewed for an identified period to determine nutritional supplement administration. The health records indicated that the nutrition supplement was administered as ordered for a specified period; the same amount of nutrition supplement continued to be administered for another specified period; and a larger amount of supplement was administered for another

specified period. Resident #004 was not provided the larger amount of nutritional supplement for a specified period as ordered by the RD for significant weight loss and as per the written plan of care.

RPN #112 was interviewed by inspector #722 during this inspection, related to resident #004's nutrition and weight loss and confirmed that the resident is receiving a meal supplement because the resident does not eat well. RPN #112 verified the amount of nutritional supplement that the resident is currently receiving. RPN #112 confirmed that the order written by the RD on a specified date for the nutritional supplement was transcribed incorrectly, and a smaller amount of supplement was administered. RPN #112 also confirmed that on a later specified date, the nutritional supplement was re-ordered by the RD and transcribed correctly.

Inspector #722 interviewed Registered Dietician (RD) #115 during this inspection, related to resident #004's nutrition and weight loss. RD #115 indicated that resident #004 is currently on a regular diet, regular texture with thin fluids and currently receives a nutritional supplement. RD #115 confirmed that the resident was ordered the meal supplement due to a nutrition risk with fair-to-poor intake, weight loss, and other medical needs. The RD confirmed that the resident was initially ordered the nutritional supplement on a specified date, and increased the amount on another specified date. RD #115 confirmed that the original order was transcribed inaccurately and that the resident received the incorrect amount of nutritional supplement for an identified period.

Inspector #722 interviewed the Clinical Coordinator (CC) #109 during this inspection, related to resident #004's nutritional supplement order. CC #109 confirmed that the supplement was increased on May 15, 2018, but that the order was transcribed incorrectly in the eMAR at a lower amount.

The licensee failed to ensure that the care set out in the plan of care for resident #004 related to nutritional supplements, was provided to the resident as specified in the plan of care. [s. 6. (7)]

3. The licensee failed to ensure that when resident #001 is reassessed and the plan of care reviewed and revised related to falls, and the plan of care is being revised because care set out in the plan has not been effective, that different approaches are considered in the revision of the plan of care related to falls.

Related to Log # 004055-18

The critical incident report related to a fall resulting in an injury requiring hospitalization involving resident #001 was reviewed. The critical incident report indicated that resident #001 had a previous fall on a specified date that also resulted in an injury requiring hospitalization.

Review of the progress notes for an identified period, indicated that on a specified date, resident #001 was found on the floor. Resident #001 was assessed and had sustained injuries. Resident #001 was transferred to the hospital and returned after receiving treatment.

Review of the plan of care for resident #001 prior to the fall on a specified date, indicated two specific interventions to reduce the risk of falls.

RN #119 was interviewed by Inspector #194 during this inspection related to the fall involving resident #001 on a specified date. RN #119 indicated that they had completed the initial assessment for resident #001 after the fall. RN #119 indicated that resident #001 was immediately transferred to hospital and that no risk assessment or post-fall assessment was completed after the fall and upon return to the home from the hospital.

Review of resident #001's plan of care after the fall on a specified date, indicated no new interventions related to falls were implemented when the resident returned to the home from the hospital.

The licensee failed to ensure that resident #001's plan of care was revised after the fall on a specified date, with different approaches considered in the revision of the plan of care, when the care set out in the plan of care was not effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; the care set out in the plan of care is provided to the resident as specified in the plan; and the plan of care was reviewed and revised when the care set out in the plan was ineffective, with different approaches considered in the revision of the plan of care;, to be implemented voluntarily.

WN #2: 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 :

(A1)
1. The licensee failed to ensure that the falls prevention program, required under O.Reg 79/10 s. 49(1), is complied with.

Related to Log #004055-18.

A critical incident report was reviewed for a fall on a specified date involving resident #001, who sustained an injury resulting in hospitalization. The critical incident report indicated that resident #001 had a previous fall on a specified date, also resulting in an injury that required hospitalization.

The Falls Prevention and Management Program (RC-15-01-01) dated February 2017 was reviewed by inspector #194 and indicated the following:

Procedures: Prevention of Falls

Flag residents at high risk of fall injury (e.g., new admission, Scott fall risk score >7, fracture risk >1) for additional monitoring, precautionary measures, and protective equipment (e.g., hip protectors, wrist guards, etc.) on admission and re-assessment. Clearly communicate responsibilities of all parties in prevention of falls and injury. See falling star/leaf flagging guide.

Post Fall Management
1. Implement post-fall clinical pathway
a. complete an initial physical and neurological assessment
d. If a resident hits head or is suspected of hitting head (e.g., unwitnessed fall) complete Clinical Monitoring Record, Appendix 10
2. Hold a post-fall huddle, ideally within the hour and complete a post-fall assessment as soon as possible

Inspector #194 reviewed the Falling Star/Leaf Flagging Guide (Appendix 7), which was last updated February 2017, and indicated the following:
- The purpose of the Falling Star/Leaf program is to identify residents at high risk of falls or fall injuries and clearly communicate to staff and other care team members standard interventions for reducing risk.
The following residents will be flagged:
- score greater than or equal to seven on the Scott fall risk screen, or
- score greater than or equal to one on Fracture risk assessment

Review of the progress notes over a specified period, and interview with resident #001 conducted by inspector #194, verified that the resident had fallen and sustained an injury on three separate occasions during the period. Two of the falls resulted in hospitalization, and one required a transfer to the hospital emergency department.

Assessments for resident #001 related to falls were reviewed and indicated the following:
- Fracture risk assessment after the first fall during the review period
- No post-fall assessments were completed after the second fall during the review period
- Fracture risk assessment after the third fall identified during the review period
- Post-fall assessment for the third fall identified during the review period indicated no requirement for a specific assessment to be completed and that the resident was on an identified medication

Review of the health records for resident #001 after the fall in on a specified date, indicated that only one identified assessment was completed between the fall and until the resident was transferred to hospital.

Inspector #194 interviewed the DOC on a specified date, related to Falls Committee team meetings in the home. The DOC indicated that a falls committee was in place at the home and met monthly, but a few meetings had been missed. The DOC and Inspector #194 reviewed the available Falls Committee minutes related to resident #001's falls during a specified period. The Falls Committee minutes did not mention resident #001 related to falls, and the DOC confirmed that resident #001 had not been placed on the Falling Star/Leaf program at the home.

RN #119 was interviewed by inspector #194 during this inspection, related to resident #001's fall on a specified date. RN #119 verified that the initial assessment for resident #001 was completed after the fall and initiated transfer to hospital, but did not complete the risk assessment or post-fall assessment for resident #001.

RN #111 was interviewed by inspector #194 during this inspection, related to an identified assessment for resident #001 after the fall on a specified date. RN #111 verified that resident #001 had an unwitnessed fall and that the identified assessment should have been initiated for the resident. Review of the clinical health records was completed by RN #111 and no evidence was noted to support that the identified assessment was provided for resident #001 on that specified date, after the fall and until the resident was transferred to hospital.

The licensee failed to ensure that the Falls Prevention and Management Program (RC-15-01-01), as required under O.Reg 79/10 s. 49(1), was complied with when resident #001 was not placed on the Falling Star/Leaf program in the home after two falls, both resulting in significant injuries that required hospitalization; a risk assessment and post fall assessment was not completed for resident #001 by RN #119 after the fall on another specified date resulting in injury; and identified assessment was not initiated for resident #001 after an unwitnessed fall on a specified date. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee failed to ensure that the falls prevention program, required under O.Reg 79/10 s. 49(1), is complied with.

Related to Log #025886-17.

A critical incident report was submitted on a specified date reporting that resident #006 fell the previous day, resulting in a significant injury requiring hospitalization.

Review of the progress notes for resident #006, for a specified period related to falls, was completed by inspector #194. The progress notes indicated that on a specified date, resident #006 was found on the floor and an assessment was completed; resident #006 was transferred to the hospital due to an injury.

Review of the assessments completed for resident #006 related to falls indicated that a post falls assessment was completed four days after a fall on a specified date.

The licensee failed to ensure that the Falls Prevention and Management Program (RC-15-01-01), as required under O.Reg 79/10 s. 49(1), was complied with when a post-fall assessment was not completed for resident #006 until four days after the fall on a specified date that resulted in a significant injury requiring hospitalization. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee failed to ensure that the long-term care home's medication management policies, as required under O.Reg 79/10 s. 114(2), were complied with.

Related to log 008715-17.

On a specified date, a critical incident report was submitted to the Director reporting that the long-term care home was investigating the documentation practices of RPN #106 related to inappropriate administration and documentation of "as needed" (PRN) narcotic analgesics to residents #023, #024, #025, #026, #027 and #028. The licensee's documentation indicated the investigation of the medication practices of RPN #106 over a specified period.

Review of the investigation documentation by Inspector #066 indicated that there were discrepancies in medication documentation for the residents indicated above, and involving RPN #106. The investigation notes indicated that the discrepancies started at a specified time, and continued for an identified period. The investigation notes also indicated that there were instances when RPN #106 signed for medications twice at the same time on the same date, and an instance

on a specified date when RPN #106 signed that a narcotic had been given to a resident when they were not on shift.

Interviews with the Administrator and the DOC by Inspector #166 indicated that the documentation in the health records for each of the identified residents was inconsistent. The Administrator and DOC both indicated that there was an instance when RPN #106 signed for a PRN medication when they were not working; as well as instances when RPN #106 signed twice for the same medication, at the same time, for the same resident. Review of the medication counts by Inspector #166 indicated that they were accurate for each of the residents audited, which was confirmed during interviews with the Administrator and DOC.

Review of medication incidents by Inspector #166 indicated inaccurate documentation of PRN medications by RPN #106. For example, on a specified date, a medication incident report was submitted indicating that RPN #106 had signed twice on the medication record for a PRN medication dose at a specific time, but was only signed once for a different time. Another medication incident was reported in April 2017, when RPN #106 had neglected to electronically sign for medication administration, but the paper medication monitoring record had been signed at two different times on the same day.

Review of the licensee's policy, The Medication Pass, policy 3-6, directs registered staff to: Chart administration of PRN medication on the electronic medication administration record, the resident's progress note, on an 'Individual PRN Administration Record', or on the reverse of the paper medication administration record, as per home policy.

Review of the licensee's policy, Medication Management, #RC-16-01-07, directs registered staff to: Administer medications following the 8 "Rights" of medication administration which includes: h. Right documentation; and 22. Ensure residents have been given their medication and the documentation has been completed upon completion of the medication pass.

Review of the licensee's investigation documentation indicated the police investigation found no evidence of misappropriation of medications and the licensee investigation proved inconclusive related to the allegation of missing/unaccounted medications. The licensee determined that RPN #106 did not follow the licensee's documentation standards related to the Medication

Management (#RC-16-01-07) and Medication Pass (Policy 3-6) policies.

The licensee has failed to ensure that the Medication Management (#RC-16-01-07) and Medication Pass (Policy 3-6) policies, as required under O.Reg 79/10 s. 114(2), were complied with. (166)

4. The licensee failed to ensure that the long-term care home's pain management program, as required under to O.Reg 79/10 s. 52(1), was complied with.

Related to log 008715-17.

On a specified date, a critical incident report was submitted to the Director reporting that the long-term care home was investigating the documentation practices of RPN #106, related to increased administration of "as needed" (PRN) medications to residents #023, #024, #025, #026, #027 and #028.

Review of the critical incident report, the licensee's investigation documentation, and in separate interviews with the Administrator and the DOC indicated that, although the medication count was correct for each of the identified residents audited, the documentation in the residents' health records was inconsistent.

Incorrect times of administration were documented and did not match the residents' individual medication records. For example, on a specified date, RPN #106 signed that a resident had been given a PRN medication on a date that the RPN was not working. RPN #106 had also signed for medication twice at the same time on the same date for the same resident.

The licensee's investigation documentation indicated that the medication administration and documentation practices of RPN #106 were reviewed for an identified time period.

Review of the electronic health record for each of the identified residents within the licensee's investigation time period related to pain management and administration of medication indicated the following:
- All identified residents had physicians' orders to be administered a regular dosage of medication, as well as a PRN order;
- All identified residents expressed experiencing pain and discomfort at intervals during the licensee's investigation time period;
- All identified residents received PRN medication during the licensees'

investigation time period; and
- All of the residents who were identified as having received PRN medications had no adverse effects, and no evidence of pain following the signing of the medication administered.

Review of the licensee's policy, Pain Identification and Management (#RC-19-01-01), related to documentation, directs registered staff to: 3. Communicate residents with new and/or unresolved pain management issues at every shift. For homes who utilize electronic documentation, the "Pain Flow Note" is to be used to record pre- and post-intervention/analgesic administration.

The licensee determined that RPN #106 did not follow the licensee's documentation standards related to Pain Identification and Management (#RC-19-01-01), related to the proper documentation when administering PRN pain medication.

The licensee has failed to ensure that the Pain Identification and Management policy (#RC-19-01-01), as required under O.Reg 79/10 s. 52(1), was complied with. (166) [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the Falls Prevention and Management program and Medication Management policy are complied with,, to be implemented voluntarily.

WN #3: 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 failed to ensure that 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.

Related to log #029490-17

On a specified date, an after-hours incident report was submitted reporting a missing medication. Several days later, a critical incident report was submitted to the Director reporting that RPN #108 approached the charge nurse and advised they were not able to find the medication that was to be administered to resident #017. The empty packaging for the medication was found on top of the medication cart.

Inspector #166 interviewed RPN #108 during this inspection. RPN #108 indicated that they opened the packaging to administer the medication to resident #017, and that they became distracted by the responsive behaviour of another resident, as well as the request of a staff member for assistance. RPN #108 indicated that they locked the medication cart and went to assist the staff member, but had left the open packaging containing the medication on top of the cart. RPN #108 indicated that they had covered up the medication, but was unable to find it when they returned to the cart. RPN #108 indicated that they notified the charge nurse and they searched for the missing medication. The police were advised and came to the home to conduct an investigation. There was no impact on resident #017, as the medication was administered to resident.

The licensee failed to ensure that a controlled substance was stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that 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,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance.

Related to log #007304-18.

A critical incident report was submitted to the Director reporting a missing medication. Review of the critical incident documentation indicated that on an identified shift on a specified date, the registered staff were checking the placement of resident #022's medication and later noticed that it was missing. The medication had been placed in a specific location on the resident and was in position when checked by the registered staff at the start of the identified shift.

Review of the electronic health record indicated that the resident's room, bathroom, garbage, laundry, as well as the resident's body was searched. A physician's order was received to reapply the medication. The resident's Substitute Decision Maker (SDM) was notified. The SDM stated that the resident had been complaining about the medication being itchy, and the SDM indicated they would not be surprised if the resident took the medication off and disposed of it and did not remember. There have been no further incidents related to the identified medication going missing for this resident.

Review of the licensee's critical incident report indicated that the after-hours pager had not been contacted regarding the missing medication. The Director was notified of the incident five business days after the incident occurred.

The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of the incident of a missing or unaccounted for controlled substance. [s. 107. (3)]

Issued on this 15th day of November, 2018 (A1)

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

Original report signed by the inspector.