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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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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
Jul 10, 2014	2014_336580_0012	S-000263-14	Resident Quality Inspection

Licensee/Titulaire de permis

FINLANDIA NURSING HOME LIMITED
c/o Sudbury Finnish Rest Home, 233 Fourth Avenue, SUDBURY, ON, P3B-4C3

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

FINLANDIA HOIVAKOTI NURSING HOME LIMITED
233 FOURTH AVENUE, SUDBURY, ON, P3B-4C3

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

VALA MONESTIMEBELTER (580), MARSHA RIVERS (576), TIFFANY BOUCHER (543)

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): June 23, 24, 25, 26, 27, 30, and July 2, 3, and 4, 2014

During the course of the inspection, the inspector(s) spoke with Residents and their Families, the Administrator, the Chief Clinical Officer (CCO), the Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), the Food Service Supervisor (FSS), Housekeeping Aides (HAs), Laundry Aides (LAs), Janitorial Aides, Dietary Aides (DAs), the Manager of Support Services (MSS), the Manager of Maintenance, the Manager of Capital Projects, the Care Plan Co-ordinator and the Staffing Co-ordinator.

During the course of the inspection, the inspector(s) conducted daily walks through the Home, made direct observations of the delivery of care and services to the resident, observed staff to resident interactions, reviewed resident health care records and reviewed various policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

On June 26, 2014, between 1515 and 1525 pm, Inspector #580 heard someone asking the resident in a room if they felt ill. Upon entry, the Inspector observed resident #003 in bed, breathing with difficulty, flushed, diaphoretic, and coughing with the bed in a Trendelenburg position (feet elevated, head lowered) between 15 and 30 degrees. The resident's family was in the room with resident #003. The Inspector asked the family why the bed was in such a position. The family told the Inspector they did not know what the Inspector meant, and when the Inspector asked the family to stand away from the bed, near the doorway, they agreed that the resident was positioned with the head of the bed low and the foot of the bed high, and did not know why the bed was in such a position. The Inspector asked the family to remain with the resident while the Inspector went to find a nurse.
At approximately 1525 pm, the Inspector asked PSW #204, who was walking in the hallway near resident #003's room, why resident #003's bed was in such a position. The staff #204 told the Inspector that they did not know why the bed was in this position and that the previous shift might have done this. Staff #204 went to resident's #003's room to check on them. At approximately 1525, Inspector #580 found RPN #216 and asked why resident #003's bed was in the position of feet up and head down. Staff #216 replied that they did not know why the bed was like this. The Inspector stated that the resident was having difficulty breathing. Staff #216 stated they would check on the resident. At approximately 1540 pm, the Inspector reported the situation to the Director of Care who went immediately to check on the resident. The DOC told the Inspector that the nurse was taking vitals on the resident and that maintenance was checking out the bed, as the staff was having difficulty adjusting the bed's positioning.
On June 26, 2014, Inspector #580 reviewed resident #003's PointClickCare care plan of June 2, 2014, which did not identify bed positioning. The care plan for resident #003 indicated a number of diagnoses. The pattern of inaction on the part of staff #204 and staff #216 jeopardized the health, safety and well-being of resident #003 who was experiencing respiratory difficulty. The position of resident's #003's bed and the fact that it remained in this unexplained position for 30 to 45 minutes, resulted in the resident being neglected until finally the DOC took some action.

The licensee failed to ensure that resident #003 was not neglected by the staff.

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 to ensure that resident #003 is not neglected by the staff, to be implemented voluntarily.

WN #2: 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. (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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. Inspector #543 reviewed resident #0374's care plan. This resident's care plan identified a stage 1 ulcer. The direct care staff are to follow the Home's protocol/regime for treating breaks in skin integrity/pressure ulcers, as well as turn and reposition this resident with skin care every 2 hours. The Inspector reviewed this resident's health care record, and there is no documentation in the Point of Care (POC) tasks list that this is being done for this resident.

The Inspector spoke with several PSWs on various units in the Home who confirmed that tasks identified in the resident's care plan are to be documented once completed, in POC. The Inspector spoke with the charge RN who confirmed that if it is written in a resident's care plan for example, to perform "q 1 hour" checks, that this does not need to be documented in POC as it is a standard of care for the Home; however, if the task is "out of the ordinary" it is absolutely necessary that staff document the task as provided to the resident, once completed, in POC. In this resident's case, turning and repositioning with skin care every two hours was not documented as provided.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

2. Inspector #543 reviewed resident #0423's care plan. This resident's care plan identified this resident has a toileting schedule. The schedule describes that this resident is to be toileted before and after meals, at bedtime as well every two hours throughout the night and whenever required. The Inspector reviewed this resident's health care record, there is no documentation in the POC tasks list that this resident is being toileted every two hours throughout the night.

The Inspector spoke with several PSWs on various units in the home who confirmed that tasks identified in the resident's care plan are to be documented once completed, in POC. The Inspector spoke with the charge RN who confirmed that if it is written in a resident's care plan to toilet the resident every two hours throughout the night, this task should be documented once completed, in POC.

The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan. [s. 6. (7)]

3. On June 18, 2014 and June 25, 2014, Inspector #580 reviewed the care plans of residents #0358, #0374, #0380, #0385 and #0407 which identified specific interventions related to decreased or impaired vision. On June 26, 2014 staff #200 and staff #201 confirmed that Registered Staff and PSWs refer to the PointClickCare (PCC) care plan for resident care information. On June 25 and June 26, 2014 eight out of eight PSWs told Inspector #580 that they were not familiar with the plan of care related to vision for the above specified residents. On July 2, 2014 Inspector #580 reviewed the Home's Resident Care Plan policy dated May 2014 which indicates that the resident care plan provides specific information about a resident, identification of unusual problems and nursing actions required to produce expected outcomes.

The licensee failed to ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care.

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 to ensure that the care set out in the plan of care for resident #0374 and resident #0423 is provided to the resident as specified in the plan and that staff are kept aware of the contents of the resident's plan of care for residents #0358, #0374, #0380, #0385 and #0407, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. On June 25, 2014 and July 2, 2014, resident #0425 reported to Inspector #580 that they require assistance with drinking and is often not offered a between meal beverage.

Inspector #576 reviewed the home's policy "Meal and Nourishment Service Times # SS-D-MNS-15" and the policy states that the service time for morning nourishments is 1000 in all resident home areas.
On June 30, 2014, Inspector #576 conducted a walk-through of the resident home areas between 1030 and 1100. The Inspector did not observe staff serving beverages or residents drinking from or holding cups in two of the four home areas. In one resident home area, the Inspector observed staff #200 serving a resident a beverage. Staff #200 stated that they had served beverages to their "assigned residents" (i.e.

those residents requiring eating and drinking assistance assigned to this staff on this shift) but was unsure if the other residents in this resident home area had been offered a beverage. In three out of four resident home areas, the Inspector was unable to locate the nourishment cart being circulated. In two out of four resident home areas, PSWs stated that the Dietary Aide (DA) would be serving morning nourishments on this day. The DAs working in these respective home areas stated that due to a staffing shortage, the PSWs would be serving morning nourishments on this day.
On June 30, 2014, in one resident home area, the Inspector observed a DA (staff #207) serving nourishments from a nourishment cart. The Inspector observed this staff record "N/A" on the Nourishment List when a resident was not in their room.
On July 2, 2014, Inspector #576 conducted a walk-through of the resident home areas between 1030 and 1100. The Inspector observed DA (staff #207) serving nourishments from a nourishment cart during this time and this staff recording "N/A" on the Nourishment List when a resident was not in their room at the time this staff passed by with the nourishment cart.

Staff #200 stated that PSWs are responsible for serving beverages and snacks to residents requiring assistance and DAs are responsible for serving beverages and snacks to other residents that do not require assistance or supervision. Staff #207 and staff #206 confirmed that DAs reference the Nourishment List to identify residents who do not require assistance or supervision for eating or drinking and only serve nourishments to these residents. Staff #207 and staff #206 also confirmed that DAs record "R" when a resident refuses nourishment and "NA" when a resident is not in their room, nor seen in a common room in the resident home area.

The Inspector reviewed the Point of Care (POC) documentation for nourishment for resident #0425, for the period of May 1, 2014 to June 30, 2014. The Inspector noted that POC documentation for morning, afternoon, and evening nourishments was not completed on all days during this period. Between-meal fluids in the morning was neither documented in POC, nor documented in POC as NA on 8/31 days in May and on 6/30 days in June. Between-meal fluids in the afternoon was neither documented in POC nor documented in POC as NA on 5/31 days in May and on 4/30 days in June. Between-meal fluids in the evening after dinner was neither documented in POC, nor documented as NA in POC, on 16/31 days in May and on 9/30 days in June. Staff #200 and staff #206 confirmed that PSWs and DAs are to document that they have offered or provided nourishments to a resident in POC.

The licensee failed to ensure that each resident is offered a minimum of a between

meal beverage in the morning and afternoon and a beverage in the evening after dinner. [s. 71. (3) (b)]

2. On July 2, 2014, resident #0425 reported to Inspector #576 that they are often not offered a between-meal snack.

The Inspector reviewed the POC documentation for nourishment for resident #0425, for the period of May 1, 2014 to June 30, 2014. The Inspector noted that POC documentation for afternoon, and evening nourishments was not completed on all days during this period. The afternoon snack was neither documented in POC nor documented as NA, in POC on 5/31 days in May and on 2/30 days in June. The evening snack was neither documented in POC, nor documented as NA, in POC on 16/31 days in May and on 11/30 days in June.

Staff #200, staff #207and staff #206 confirmed that PSWs and DAs are to document in POC under nourishments when they have offered or provided a resident with a between meal snack or beverage.

Inspector #576 reviewed the Home's policy titled "Nourishment Service", and the policy states that snacks shall be offered to all residents at mid-afternoon and at bedtime unless contraindicated in the care plan. Inspector #580 reviewed resident #0425's care plan which indicates the following interventions:
- have a specific beverage at nourishment and cookies at HS snack (revised on April 23, 2012),
- push fluids of 250 mls at nourishments (initiated April 23, 2012), and
- document amount of food, fluids and nourishment taken (initiated November 8, 2011).

The licensee failed to ensure that each resident is offered a minimum of a snack in the afternoon and evening. [s. 71. (3) (c)]

3. Inspector #576 reviewed the Home's nourishment menu and noted that the planned morning snack for each day of the four week menu cycle includes a choice of juice or fruit. The nourishment menu also states that the morning snack for the diabetic/reducing diet is an unsweetened drink and 1/2 cup of fruit. On June 30, 2014 and July 2, 2014, Inspector #576 observed the morning nourishment services. On both days, the Inspector observed various cold beverages being distributed to residents, but did not observe fruit on the nourishment cart or observe staff offering

any residents fruit. Staff #206 and staff #207 stated that they were not aware that the home had a nourishment menu and confirmed that they only serve a beverage for morning snack and fruit is not provided, unless it is specifically requested by a resident.

The licensee failed to ensure that the planned menu items are offered and available at each snack.

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 to ensure that all residents, including resident #0425, are offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, that all residents, including resident #0425 are offered a minimum of a snack in the afternoon and evening, and to ensure that the planned menu items are offered and available at each snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. Inspector #576 reviewed the Home's policy "Food Transport, holding and service #SS-D-MNS-09". This policy states that "all hot food must be above 150 to 160 degrees F (65 to 71 degrees C) and cold foods must be between 41 and 50 degrees F (5 to 10 degrees C)". The Inspectors reviewed one week of food temperature records for each resident home area taken during the period of May 26, 2014 to June 22, 2014 . The Inspector noted that point of service temperatures for all food items were not always documented and that temperatures for entire meals were not documented on 11 occasions. Recorded temperatures for hot food items served were less than 150 degrees F on 91 occasions and recorded temperatures of cold food items served exceeded 50 degrees on 48 occasions. The Manager of Support Services confirmed that temperatures of hot food items outside the range of 150-160F would be considered by the Home to be "unsafe" and that temperatures of cold food items outside the range of 41-50F would be considered by the Home to be "unsafe".

The licensee failed to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is safe to the residents.

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 to ensure that the home has a dining and snack service that includes food and fluids being served at a temperature that is safe to the residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. On June 25 2014, during a walk-through of the Home, Inspector #580 was unable to locate individual residents' nail clippers. Staff #202 stated they bring nail clippers from their own home and use the same pair on all residents, and sanitizes in between residents for five minutes using hand sanitizer poured into a small cup. Staff #203 and staff #204 confirmed that each resident does not have their own nail clippers and that staff use hand soap, bath soap or Purell to clean nail clippers in between residents. Inspector reviewed the Home's policy "Cleansing of Nail Clippers" dated May 2014, and the policy states that nail clippers are to be submerged for five minutes in an approved disinfectant (Virox).

The licensee failed to ensure that all staff participate in the implementation of the program.

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 to ensure that all staff participate in the implementation of the infection prevention and control program specifically related to the cleaning of nail clippers, to be implemented voluntarily.

WN #6: 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 :

1. On June 23 2014, during the initial walk-through inspection of the Home, Inspector #580 observed seven medicated creams on one tub area shower room cart: four with partial resident names, two with illegible names, one with the name partially rubbed off

and six of the seven with unclear directions for administration.
On June 26 2014 at approximately 0950, Inspector #580 observed four illegibly labelled medicated cream jars of Infazinc stored in the medication cart.
On June 27, 2014 Inspector 580 observed three medicated cream jars with unclear labels in another unit's medication storage room.

On June 26, 2014, staff #208 told Inspector #580 that the names on the medicated cream jars were not legible but stated that she knows the residents' names and therefore knows whose medication the non-legible named medicated cream belongs to. On June 25, 2014, the Chief Clinical Officer confirmed to Inspector #580 that the medicated creams were not properly labelled.

On July 3, 2014, Inspector #580 reviewed the Home's following policies:
-the Administration of Prescription Products by UCP policy dated May 2014 which states that a UCP may apply a prescription cream, ointment or other topical preparation/product to a resident as long as the Unregulated Care Provider (UCP) ensures directions on the label coincide with directions provided by registered staff prior to use.
- Medication Safety policy dated May 2014, referencing the Medisystem Pharmacy Drug Inventory Control Index No 02-06-10 and the Drug Inventory Management Index No 05-02-20 which reference the MediSystem Pharmacy Medication System Index No 04-01-10, which states that all medications for individual residents must be labelled with a prescription number: the resident's name; the date; the medication name, strength, dosage form, manufacturer, quantity, directions for use and the expiration date on the original container; the physician's name; and the name, owner, address, and telephone number of the dispensing pharmacy.

The licensee failed to ensure that the policies related to medication management are complied with. [s. 8. (1)]

2. Inspector #543 reviewed three census sample immunization records. Upon review, some discrepancies were identified in regards to complying with the Home's Policy - Tuberculin Testing/Residents (ICM-Sr-S4-01) effective June 2005. This policy states that all newly admitted residents shall be screened within fourteen days using the two step method tuberculin skin testing unless previous documentation of induration is given or it is medically contraindicated. The RN or RPN will obtain a physician's order for the skin test within fourteen days of admission. If the result is negative then a second test is given fourteen days after the first test. If the result is positive, a second

test will not be completed.

Inspector #543 reviewed a larger census sample (eight residents) and the following was identified:
-Resident #0386 was admitted to the Home in 2008. Step 1 TB was administered about 19 weeks later. It was noted that two Step 2 TBs were identified, one administered in December (more than 4 months after admission) and another less that 14 days after Step 1.
-Resident #0391 was admitted to the Home in 2009. Step 1 TB was administered in 2010 (more than 9 months after admission) and Step 2 was administered less than 14 days after Step 1.
-Resident #0381 was admitted to the Home in 2007. Step 1 TB and Step 2 are documented as being administered more than 7 months after admission.
-Resident #0400 was admitted to the Home in 2010. Step 1 TB was administered more than 14 days after admission.
-Resident #0425 was admitted to the Home in 2011. Step 1 TB was administered more than a month after admission and Step 2 was administered less than 14 days after Step 1.
-Resident #0403 was admitted to the Home in 2010. Step 1 TB was administered four months after admission and Step 2 was administered less than 14 days after Step 1.
-Resident #0394 was admitted to the Home in 2009. Step 1 TB was administered more than 14 days after admission and Step 2 was administered less than 14 days after Step 1.
-Resident #0393 was admitted to the Home in 2009. Step 1 TB and Step 2 are documented as being administered three months after admission.

Inspector #543 spoke with the Chief Clinical Officer who confirmed that the above does not comply with the Home's policy.

The licensee failed to ensure that the Home's policy - Tuberculin Testing/Residents (ICM-Sr-S4-01) was complied with. [s. 8. (1)]

3. On July 2, 2014 Inspector #580 reviewed the Home's Transfer to Hospital and Readmission policy NM-R-11 dated January 2011, which indicates that the charge nurse or delegate will perform a skin assessment within 24 hours of readmission; and the Home's Skin Care and Wound Management Policy dated May 2014, which indicates that within 24 hours upon return from hospital, a systematic "head to toe" skin assessment, completed Skin Assessment and Braden Scale assessment in PCC

will be conducted by a member of the registered staff.
On July 2, 2014 Inspector #580 reviewed the Home's Return From Hospital Checklist for resident #0374 and found the checklist to be initialed as completed and indicating that the skin assessment was completed within 24 hours after readmission on PCC. However Inspector #580 found no Skin Assessment or Braden Scale Assessment initiated or completed within 24 hours of resident #0374's readmission to the Home. On July 2, 2014 staff #205 confirmed to Inspector #580 that upon return from a hospital stay, a Return From Hospital Checklist is completed for all residents which includes a skin assessment but could not find a skin assessment done for resident #0374 within the first 24 hours of return from hospital. On July 2, 2014 the Chief Clinical Officer confirmed to Inspector #580 that skin assessments are to be done within 24 hours of residents re-admitted from hospital and further stated that the 24 hour assessment on resident #0374 was not carried out until thirteen days later.

The licensee failed to ensure compliance that the Home's Transfer to Hospital and Readmission policy was complied with.

WN #7: 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. On June 23, 2014 during the initial walk-through of the Home, Inspector #580 observed prescribed creams labelled with different residents' names in a container in one of the Home's unit tub area. The Inspector spoke with the Chief Clinical Officer, who confirmed that the medicated creams were stored improperly and should be stored in the medication room or the medication cart. The Home's Medication Administration dated May 2014, states that prescribed medications are to be kept in the medication storage area accessible only to registered staff.

The licensee did not ensure that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies, that is secure and locked, and that protects the drugs from humidity or other environmental conditions in order to maintain efficacy.

Issued on this 16th day of July, 2014

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