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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 23, 2015	2015_324567_0011	027253-15	Resident Quality Inspection

Licensee/Titulaire de permis

PROVIDENCE HEALTHCARE
3276 St. Clair Avenue East TORONTO ON M1L 1W1

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

PROVIDENCE HEALTHCARE
3276 ST. CLAIR AVENUE EAST SCARBOROUGH ON M1L 1W1

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

SOFIA DASILVA (567), JULIENNE NGONLOGA (502), SHIHANA RUMZI (604)

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): October 6, 7, 8, 9, 13, 14, 15, 16, 19, 20, 22, 23, 26, 2015.

The following intakes were inspected concurrently with the Resident Quality Inspection: Log no. 006708-14 and Log no. 004054-15

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Care Managers, Director of Dietary Services, Registered Dietitians, Environmental Services Manager, Housekeeping staff, Resident Assessment Instrument Minimum Data Set (RAI-MDS) Coordinator, Charge Nurses, Registered Staff, Resident Assistants, Residents, Substitute Decision Makers (SDMs), family members, Presidents of Residents' and Family Council.

During the course of the inspection, the inspectors conducted a tour of the home, made observations of: meal service; medication administration; staff and resident interactions; provision of care, conducted reviews of health records, complaints and critical incident logs, staff training records, meeting minutes of Resident and Family Council meetings, relevant policies and procedures and House of Providence (HOP) order logs.

The following Inspection Protocols were used during this inspection:

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

During the course of this inspection, Non-Compliances were issued.
- **12 WN(s)**
- **1 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

During the initial tour of the home, conducted on October 6, 2015, the following doors were noted to be unlocked:

Balsam House: chutes room door – laundry and garbage chute, contained a dirty laundry hamper
Redwood House: clean utility room - contained liquid oxygen tank, bed cranks, microwave, gloves, bar fridge, linen cart
Spruce House: chutes room door - laundry and garbage chute room containing a bag of dirty incontinence products on a hamper
Pine House: chutes room door - laundry and garbage chute
Aspen House: chutes room door - laundry and garbage chute
Cedar House: soiled utility room - contained soiled incontinence products
Walnut House: chutes room door - laundry and garbage chute
Walnut House: clean utility room – contained razors and liquid oxygen

The doors were equipped with a pin pad entry system, the pin pad light was red, indicating the doors were locked. The inspector was able to push the doors open and enter the room; Nurse Manager #124 arrived, observed each door with the inspector, and confirmed the above doors did not lock even though the pin pad light was red. The doors were manually locked with a key to ensure the doors were locked.

An interview with the DOC confirmed the above findings and indicated all doors leading to non-residential areas are to be kept locked at all times. [s. 9. (1) 2.]

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 doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act.

On October 16, 2015, at 0915 hours, the inspector observed an unattended medication cart in an identified home area outside a resident's room. The electronic Medication Administration Record (e-MAR) screen had been left open to resident #018's medication administration record and was visible to anyone passing by. Resident #019 was sitting next to the medication cart.

Interviews held with RPN #122 and the DOC confirmed the e-MAR screen was unlocked and was visible to anyone passing by and as such did not protect resident #018's personal health information. RPN #122 and the DOC confirmed that the e-MAR screen is to be kept locked at all times when the cart is left unattended. [s. 3. (1) 11. iv.]

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

Review of resident #012's progress notes revealed that the resident returned from the hospital with an assistive device on an identified date in 2015. The resident had been assessed by the Providence Hospital Registered Dietitian (RD) and was given an order related to the assistive device, item A.

On readmission to the home the resident was assessed by an on-call RD, who confirmed the order for item A. The nursing staff requested item A from the dietary department. An item, B, with a different profile to what was ordered was sent for the resident.

Interviews with dietary staff #135 and the home RD confirmed that neither the RD or physician were consulted about item B being supplied instead of item A.

Review of the progress notes dated for an identified date in 2015, revealed the home RD had documented that item A was provided to the resident since the resident had returned from hospital a week earlier. The RD then changed the order to a different, more appropriate choice, item C.

Review of the HOP Weekly Supplies List, for an identified date, revealed item A was ordered for resident #012.

Interview with dietary staff #135 confirmed he/she was sending item B for resident #012, because he/she did not have item A in his/her inventory and did not communicate this information to the RD. Interview with the Director of Nutrition Services confirmed the home had never carried item A. Interview with the RD confirmed the resident used the assistive device with item B, which is different from item A. He/she indicated dietary staff should have collaborated with nursing staff and consulted with the RD or the physician about item A not being available in the home. [s. 6. (4) (a)]

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.

Observations conducted throughout the day on October 14 and 15, 2015, revealed resident #004 had a area of skin alteration which was discoloured and did not have a protective dressing on it.

A review of resident #004's written plan of care dated in August of 2015, revealed the resident was to have a protective dressing over the identified skin alteration for protection and comfort.

An interview with RPN #112 and PSW #113 confirmed the resident did not have a protective dressing over the skin alteration for protection and comfort and that they did not follow the plan of care set out for resident #004.

Interview with the DOC confirmed if the plan of care states to apply a protective dressing to resident #004's, it should have been done and staff did not follow the care set out in the plan of care. [s. 6. (7)]

3. An interview with resident #012's POA revealed the resident is transferred to his/her wheelchair after lunch and stays in his/her room.

A review of resident #012's written plan of care revised on an identified date in 2014, revealed the resident will accept identified activities over the next 3 months. The activation staff will ensure the resident is portered to and from the identified activities.

Review of the Multi-Day Participation Report for resident #012 over an identified period of time in 2015, revealed the resident participated in two sessions of the identified activities.

Interview with activation staff #106 confirmed the resident had attended activities once or twice in the past two months.

The Activation and Program Manager #107 reviewed the Multi-Day Participation Report for resident #012 for the identified period and confirmed resident #012 had not attended the activities as specified in his/her plan of care. [s. 6. (7)]

4. Review of resident #012's written plan of care revised on an identified date in 2015, revealed the resident was at high risk related to his/her health conditions. Review of resident #012's progress notes revealed the resident returned from the hospital with an assistive device and a related order for item A at an identified time in 2015.

Interview with the Director of Nutrition Services and the home's Registered Dietitian (RD) revealed that when the resident was readmitted to the home, he/she was assessed by an on-call RD who confirmed the resident's order for item A. The nursing staff requested item A, but instead, item B was sent by the dietary department and given to the resident by nursing staff without consultation with the RD or MD.

Further review of the progress notes revealed the home RD documented that item B had been used for the resident since his/her return from hospital a week earlier. He/she then changed the order to item C.

Interview with the home's RD indicated the resident was given the wrong item and confirmed that item B is different from item A. He/she stated the specific differences between items A and B.

Interview with the Director of Nutrition Services confirmed the resident's written plan of care was not provided as specified in the plan, as the resident was provided item B because item A was not available in the home. [s. 6. (7)]

5. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Record review for resident #001 revealed an identified weight and height and a Body Mass Index (BMI) lower than 23 on an identified month in 2015.

Review of the resident's progress notes and nutritional assessment did not indicate the resident was referred to or assessed by the registered dietitian (RD) for a low BMI.

Interview with RPN #100 revealed there was no plan to address the low BMI.

Interview with the home's RD revealed any BMI under 23 is considered low and should be flagged as a potential nutritional concern and these residents should be referred and assessed by the RD. After reviewing the resident's nutritional assessment in PointClickCare, the RD confirmed nothing had been done to address resident #001's low BMI. [s. 6. (10) (b)]

6. An interview with resident #012's POA revealed the resident is transferred to her wheelchair after lunch and kept in her room .

Review of the resident admission assessment revealed the resident had identified an interest in specific activities.

Review of resident #012's written plan of care revised in an identified month in 2014, revealed the resident was interested in specific programs and would attend a certain number of these per week over the next 3 months. The activation staff will ensure the resident is portered to and from programs of interest. Further review revealed the resident had a new health condition in early 2015, and was using an assistive device as of mid-2015.

Interview with activation staff #106 confirmed the resident had attended activities once or twice in the past two months, because of his/her health condition and his/her needs related to the assistive device.

Interview with Activation and Program Manager #107 confirmed resident #012's written plan of care had not been reviewed or revised since he/she was admitted on a specified

date in 2014. [s. 6. (10) (b)]

7. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change.

Observation of resident #005 revealed that the resident was lying in bed with an assistive device in place.

Review of the resident's progress notes and interview with an identified caregiver and RA #131 revealed the resident had experienced a significant change as a result of an incident and as a result, the resident was no longer ambulatory and required total care.

Review of the written plan of care for an identified month in 2015, revealed the written plan of care had not been updated to reflect the change in condition and the required care. Interview with registered staff #127 confirmed that the care plan had not yet been revised. Review of the written plan of care revealed that it was revised 8 days after the resident experienced the change. Interview with the Informatics Specialist confirmed that 8 days is too long to wait to revise the written plan of care. [s. 6. (10) (b)]

WN #4: 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. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system, that is put in place, is complied with.

On October 22, 2015, in the East Houses on the third floor, observation of medication carts revealed open eye drop bottles. These bottles had not been dated to indicate the date the bottles had been opened, for the following residents:

-Resident #021, Resident #022, Resident #023 and Resident #024.

Review of the home's policy titled, Expired and Dating of Medications-Section 5-1, Procedure 3, reads: Designated medications i.e. eye drops, insulin, must be dated when opened and removed from stock when expired and further referred the reader to "recommended expiry dates once product is opened" section in the policy.

Interviews with RPN #115 and the DOC confirmed the above findings and stated staff did not follow the home's policy relating to dating eye drop medication that had been opened. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, its furnishings and equipment are maintained in a safe condition and in a good state of repair.

On October 6 and 22, 2015, during lunch meal service observation, the inspector observed, in an identified servery, the protective cover on the inside of the refrigerator was ripped and the insulation material was exposed.

Interview with dietary aide #104 and the Food Service Supervisor (FSS) revealed that dietary aide #104 had reported this finding to the FSS a few weeks prior to the start of the RQI inspection. The FSS confirmed the above concern had been reported to her. Review of maintenance records revealed there was no documentation to indicate any steps had been taken to repair or replace the refrigerator. [s. 15. (2) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily accessed by residents at all times.

Observations on October 8, 13, 14, 2015, revealed that resident #012's call bell was attached on the left side bed rail, close to the head of the bed.

Interview with RA #114 confirmed the call bell should not be attached on the left side bed rail close to the head of the bed, instead it should be clipped on the bed sheet so that the resident can access it, if needed.

Interview with RPN #116 confirmed the call bell should be within reach of the resident all the times. [s. 17. (1) (a)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine is supported and individualized to promote comfort, rest and sleep.

Review of a specified Ministry of Health and Long-Term Care document, revealed the resident's Power of Attorney (POA) stated the resident is assisted to his/her wheelchair in the morning and put back in bed later in the day. The report also stated that staff said the resident's health status is the reason they do this. The resident's POA has told them that he/she doesn't want the resident up in the wheelchair for a specified period of time but they still continue to do this.

Observation on October 7, 2015, revealed the identified resident is transferred from bed to wheelchair after lunch daily.

Review of the resident's admission assessment from a specified date, revealed the resident likes to go back to bed after lunch to rest. Review of the resident's current plan of care revealed the resident has declined and all decisions are made by the POA for Care. Review of the identified resident's plan of care revealed that on a date in mid-2015, RN #136 revised the plan of care to indicate that the identified resident gets up after lunch and goes back to bed after supper every other day due to altered skin integrity.

Interview with the POA for Care, on an identified date, revealed the resident's afternoon naps are not respected. On an identified date, the POA had temporarily agreed for the resident to stay in bed while he/she had an area of altered skin integrity. Once the area was healed, he/she asked the home to transfer the resident to his/her wheelchair in the morning, back to bed after lunch for his/her nap and back to the wheelchair after his/her nap, but staff told him the resident only gets out of bed once in the day due to the residents health status.

Interviews with RAs #111, #117 and RPN #116 confirmed the resident is transferred to his/her wheelchair after lunch and is transferred back to bed after supper. [s. 41.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A review of a MOHLTC report, indicated that resident #012 was not assessed for his/her impaired skin integrity and had concerns related to a specified part of his/her body.

Review of resident #012's documentation revealed a number of areas of altered skin integrity in early 2015.

A review of the "Assessment" tab in PCC did not reveal a follow-up skin assessment for resident #012's altered skin integrity.

An interview held with the home's Skin and Wound Champion, RN#118, on October 22, 2015, revealed a weekly tracking assessment should have been carried out for resident #012's above-mentioned skin and wound conditions. RN#118 confirmed weekly tracking assessments were not found in PCC.

An interview with the DOC confirmed skin and wound assessments for the identified areas of skin integrity for resident #012 should have been carried out on a weekly basis. The DOC stated she would be in contact with the home's Skin and Wound Champion to follow-up with the above-mentioned skin and wound concerns. [s. 50. (2) (b) (iv)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that heights are taken annually.

Review of resident clinical records revealed the following were the dates when the identified residents' heights were last taken:

-resident #006: November 2013
-resident #027: November 2003
-resident #028: February 2011
-resident #029: August 2013
-resident #030: April 2014
-resident #031: May 2014
-resident #032: October 2011
-resident #033: June 2010

Interview with the Director of Care confirmed that annual heights are to be taken on every resident and that a plan had already been put in place to address the issue. [s. 68. (2) (e) (ii)]

WN #10: 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 are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs.

Medication cart observations carried out on October 22, 2015, on an identified home area, revealed the following expired medications were stored in the medication cart:
-Potassium Chloride bottle: expiration date of November 2014
-Koffex syrup: expiration date of July 2015
-Micro K 100mg bottle: expiration date of September 2015

Interviews conducted with RPN #115 and the DOC confirmed the expired medications should not be stored in the medication cart. Expired medications were immediately removed from the medication cart by RPN #115. [s. 129. (1) (a)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times, when not in use.

On October 16, 2015, at 0918 hours, inspectors #604 and #502 observed an unattended medication cart stored outside an identified resident's room.

The medication cart was left open, as inspector #604 was able to open the drawers of the medication cart. Resident #019 was sitting in his/her wheelchair close to the unlocked medication cart.

An interview with RPN #122 confirmed the medication cart was unlocked and was accessible to anyone passing by.

Interviews conducted with RPN #122 and the DOC confirmed staff left the medication cart unlocked and the medication accessible to anyone passing by. [s. 130. 1.]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 141. Licensee to stay in contact

Specifically failed to comply with the following:

s. 141. (1) Every licensee of a long-term care home shall maintain contact with a resident who is on a medical absence or psychiatric absence or with the resident's health care provider in order to determine when the resident will be returning to the home. O. Reg. 79/10, s. 141 (1).

Findings/Faits saillants :

1. The licensee has failed to maintain contact with a resident who is on a medical absence or with the resident's health care provider in order to determine when the resident will be returning to the home.

On October 6, 2015, the inspector noted that resident #034 was not in the home, as the door to his/her room was locked. Interview with registered staff #133 revealed that he/she had been transferred to hospital on an identified date 2015, related to the resident's health condition. When asked by the inspector whether he/she would be coming back to the home in the next couple of days, the registered staff responded that he/she did not know. The registered staff also stated that he/she had not called the hospital and that there was no time to call and that even when they do call, that the hospital does not give out the resident's information.

Review of resident #034's progress notes did not reveal documentation relating to contacting the hospital.

Interview with the DOC confirmed that staff are required to call the hospital to find out the resident's status and to get information about when they are expected to return. The DOC confirmed that if staff are unable to get information, they are expected to document and the next shift will try again. As well, if the hospital tells them they can't share information, then staff are to call the POA to get information on the resident's return. [s. 141. (1)]

Issued on this 25th day of January, 2016

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

Original report signed by the inspector.