Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Amended Public Report (A1)

Report Issue Date: November 1, 2022	
Inspection Number: 2022-1238-0004	
Inspection Type: Complaint	
Licensee: North York General Hospital	
Long Term Care Home and City: Seniors' Health Centre, North York	
Inspector who Amended Stephanie Luciani (707428)	**Inspector who Amended Digital Signature** Stephanie Luciani Digitally signed by Stephanie Luciani Date: 2022.11.24 09:12:23 -05'00'
Additional Inspector(s)	

AMENDED INSPECTION REPORT SUMMARY

An administrative change to the inspection report is required. There is no change to the narrative of the finding(s)/ground(s) or the determination of compliance.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 24, 2022
October 25, 2022
October 26, 2022
October 27, 2022
October 28, 2022

The following intake(s) were inspected:

- Intake: #00009237- related to medication management.

The following **Inspection Protocols** were used during this inspection:

Medication Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Obtaining and Keeping Drugs

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

The licensee has failed to ensure that the resident's medications were stored in an area or medication cart that was secure and locked.

Rationale and Summary

(a) On a date in July 2022, staff #105 administered a medication to the resident in the morning at their bedside. Later that afternoon, the resident's family member arrived, and the medication was brought to staff #105's attention.

The home's investigation notes indicated staff #105 left the medication at the resident's bedside after administration earlier that day.

The home's policy titled "Medication Cart" directed registered staff to store all active medications in the medication cart.

Associate Director of Care (ADOC) acknowledged that medications were to be stored in the medication cart and that in this situation, the medication was not stored in the medication cart after administration, as per the home's policy.

(b) A complaint was brought forward to the Ministry of Long-Term Care related to concerns about a prescribed medication that was left in the resident's bathroom for a prolonged period of time.

A review of the resident's clinical records indicated the prescribed medication could be self-administered or self-administered with supervision.

The home's policy titled "Self-Administration of Medications" indicated medications that residents can self-administer or self-administer with the supervision of registered staff, must be stored in the

medication cart or medication room, but may be provided for administration at the resident's request.

The ADOC acknowledged that the prescribed medication was left in the resident's bathroom and not stored in the medication cart, as per the home's policy. The ADOC acknowledged the risk of leaving the prescribed medication in the resident's bathroom could lead to the improper use of the medication.

Failure to ensure medications were stored in an area or medication cart that was secure and locked, increased the risk of the resident self-administering the medication and improper use of the medication.

Sources: The resident's clinical health records, review of the home's "Medication Cart" Policy, review of the home's "Self-Administration of Medications" Policy, and interviews with staff.

[707428]

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