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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
May 6, 2015	2015_290551_0011	O-001791-15	Resident Quality Inspection

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD METCALFE ON K0A 2P0

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

MEGAN MACPHAIL (551), ANANDRAJ NATARAJAN (573), ANGELE ALBERT-RITCHIE (545), RENA BOWEN (549)

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): April 20-24 and 27-30, 2015.

The following logs were inspected as part of the Resident Quality Inspection: O-001683-15, O-001514-15, O-001029-14 and O-000882-14.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers(PSWs), Registered Nursing Staff, the Registered Dietitian, Housekeeping Staff, the PSW Care Coordinator, the RAI Coordinator, the Manager of Recreation and Quality Improvement, the Director of Food Service, the Manager of Human Resources, the Environmental Manager, the Assistant Director of Care, the Director of Care and the Executive Director.

The inspector(s) observed meal services, reviewed resident health care records, toured resident and non residential areas, reviewed several of the home policies and procedures, observed a medication pass and reviewed Residents' Council meeting minutes.

The following Inspection Protocols were used during this inspection:

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

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

9 WN(s)
6 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 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident as it relates to the application of Resident #3's palm protectors.

On April 20, 2015 Inspector #545 noted that a palm protector was laying on the bedside table in Resident #3's room. The palm protector was identified as belonging to Resident #3.

Resident #3 has contractures of both hands. On a day during the inspection, Inspector #549 observed Resident #3 in the main lounge with the palm protector on the resident's right hand.

During an interview with PSW #102, it was indicated to Inspector #549 that the palm protector has written directions on the palm protector itself. The written directions indicate to apply the palm protector to the resident's left hand. PSW #102 indicated that she applies the palm protector to the resident's right hand as the resident has some function with the left hand if the palm protector is not on the left hand.

PSW #102 indicated that there is no documentation indicating when or under what circumstances the palm protector is to be put on Resident #3.

On April 24, 2015 RPN #101 completed a review of the resident's plan of care in the presence of Inspector #549 and was unable to locate any documentation giving clear direction to the direct care staff and others who provide direct care to the resident related

to the application of Resident #3’s palm protector. [s. 6. (1) (c)]

2. The licensee has failed ensure that the care set out in the plan of care for Resident #15 in relation to transfers was provided to the resident as specified in the plan.

Resident #15 has resided at the home for several years and has multiple diagnoses.

Inspector #573 reviewed the Interdisciplinary Care Conference Summary that was completed for Resident #15 in March 2015, Resident #15's plan of care and observed transfer logo above the resident's bed. Each of these identified that Resident #15 required two person transfers with pole.

In an interview with Resident #15, he/she indicated that he/she is usually transferred from bed to chair by one staff member.

On April 28, 2015 Inspector #573 interviewed PSW #128 about Resident #15 in relation to lifts and transfers. PSW #128 indicated that Resident #15 is usually transferred from the bed to chair by one person, and sometimes if Resident #15 is weak, she would request assistance from other staff for transfers.

The “Activities of Daily Living – Transferring” report from the Point of Care program for a specified period between March and April 2015, for Resident #15, was reviewed by the Inspector. During this time frame, it was recorded that on forty one (41) occasions Resident #15 was transferred by one person physical assistance.

On April 28, 2015 the PSW Care Coordinator who is the primary lead for the Transfers Team in the home confirmed to the Inspector that Resident #15 is to be transferred by two staff members with the pole as per the care plan since Resident #15 is unpredictable due to his/her physical condition.

Resident #15's care set out in the plan of care, to have two staff members perform all transfers was not provided to the resident as specified in the plan. [O-001683-15] [s. 6. (7)]

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 #15 is transferred by two staff members as specified in the plan of care, to be implemented voluntarily.

WN #2: 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 are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not supervised by staff.

There are several doors in the home leading to non-residential areas.

Three such doors were identified within two resident care corridors.

In the Maple Hill corridor there is a door leading to the clean utility room and a door leading to the equipment storage Room. On the equipment storage room door there is a sign that states Keep Door Closed. In the Walnut Trail corridor there is a door leading to the clean utility room.

All of these doors were observed to be equipped with a key pad style lock.

Residents who reside in the Maple Hill and the Walnut Trail corridors are required to pass by these doors to enter all other parts of the home such as the dining room, the

nursing station, the hairdresser and the Atrium at the front of the home.

On April 20, 2015 at 09:30am, April 21 at 11:20am and April 22 at 2:10pm, Inspector #549 found all three doors to have the key pad locking mechanism engaged, however all three doors were found to be open and unsupervised.

On April 23, 2015 the Environmental Manager confirmed to Inspector #549 that all three doors lead to non-residential areas. The Environmental Manager indicated to Inspector #549 that she does not want residents in these rooms.

The Environmental Manager indicated that all three doors are usually kept closed and locked at all times. The Executive Director also confirmed that all three doors are usually kept closed and locked at all times.

The Environmental Manager indicated to Inspector #549 that the door closure which is installed at the top of the equipment storage room door on Maple Hill needed to be adjusted. The Environmental Manager indicated that the adjustment will ensure that the door will close all the way so the key pad lock mechanism can engage, keeping the door closed and locked.

The clean utility door on Maple Hill and the clean utility door on Walnut Trail do not have door closures installed to ensure the doors close all the way allowing the key pad lock mechanism to engage.

On April 24, 2015 the Environmental Manager indicated to Inspector #549 that the door closure for the equipment storage room on the Maple Hill corridor had been adjusted to ensure that the door closes, and the key pad locking mechanism engages, and that the clean utility room door on the Maple Hill corridor has been equipped with a door closure to ensure the door closes and the key pad locking mechanism engages. The Environmental Manager stated that the door closure for the clean utility room door on the Walnut Trail corridor had been ordered.

Several observations throughout the day on April 23, 27, 28 and 29, 2015 by Inspector #549 found all three doors to be closed and locked. [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 are kept closed and locked when they are not supervised by staff, to be implemented voluntarily.

WN #3: 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 is available in every area accessible by residents.

The home is equipped with an audio/visual resident-staff communication and response system that is available at each bed, toilet and bath location.

During a tour of the home, it was noted by Inspector #549 that there is a large area at the entrance of the home adjacent the main dining room which seats approximately 25 to 30 residents. The home's staff have identified this resident area as the Atrium.

Over the course of the inspection, it was observed that the Atrium was used for resident social gatherings with families and friends, several activities, a resident council meeting and a memorial service.

Inspector #549 noted that the Atrium is not equipped with an audio/visual resident–staff communication and response system. Inspector #549 spoke with several staff members who also could not identify a resident-staff communication and response system in the Atrium.

There is a Chapel to the left of the Atrium which can accommodate approximately 10 to 15 residents. Inspector #549 observed on April 20 and 29, 2015 a small group of residents participating in an activity in the Chapel.

Several staff indicated to Inspector #549 that residents are able to enter the Chapel area at any time unsupervised. Inspector #549 noted that the Chapel is not equipped with an audio/visual resident-staff communication and response system.

On April 23, 2015 the Environmental Manager and the Executive Director confirmed to Inspector #549 that there is no resident-staff communication and response system in the Atrium or in the Chapel.

On April 29, 2015 the Environmental Manager indicated to Inspector #549 that the home's resident-staff communication and response system provider has been contacted and that the process for installing a resident-staff communication and response system in the Atrium and Chapel has been initiated. [s. 17. (1) (e)]

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 resident-staff communication and response system is available in every area accessible by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident’s health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken when Resident #9’s body weight changed 5% or more over one month.

The Registered Dietitian (RD) was interviewed and stated that the following interventions were available in the home and could be implemented to increase a resident’s caloric intake such as in the case of undesired weight loss: Resource 2.0, Boost 1.5, high protein milk, high protein pudding, Great Shake and special snacks.

Resident #9 has resided at the home for several years. According to the care plan, he/she is assessed as being at high nutritional risk and eats a texture modified diet. Resident #9 has been receiving oral supplements with medication passes and in the afternoon since 2013.

PSW #116, RN #129 and RPN #101 were interviewed and stated that Resident #9 drank

her oral supplements well.

Resident #9's weight declined significantly between July and August 2014. The weight loss was assessed on October 1, 2014 when the Registered Dietitian (RD) wrote a late entry progress note. No action was taken to address the undesired weight loss.

Resident #9's weight declined significantly between March and April 2015. The weight loss was assessed when the MDS assessment was completed in April 2015. No action was taken to address the undesired weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

2. The licensee has failed to ensure that actions were taken when Resident #16's body weight changed 5%, or more, over one month and 7.5%, or more, over three months.

Resident #16 has resided at the home for several years. According to the care plan, he/she is assessed as being at severe nutritional risk and eats a texture modified diet Resident #16 receives oral supplements with medication passes (since 2011) and with lunch and supper (since 2014). He/she also receives a special morning snack (since 2014).

Resident #16's weight declined significantly between November and December 2014 and continued to decline until February 2015. During this three month period between November 2014 and February 2015, Resident #16 had lost over 15% of his/her body weight. These weight changes were assessed by the RD, however no action was taken to address the undesired weight loss. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

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 actions are taken when a resident's body weight changes of 5% or more, over one month; 7.5% or more, over three months; 10% or more, over six months; or any other weight change that a compromises the resident's health status, to be implemented voluntarily.

WN #5: 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 restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On April 29, 2015 Inspector #545 observed a large amount of prescribed topical creams in the Treatment Room located near the Nursing Station.

The Treatment Room is accessible to all staff in the home using a four digit keypad combination. In the Treatment Room, Inspector #545 observed an unlocked treatment cart with prescribed topical creams in the first and second drawers and two white plastic baskets with many prescribed topical creams, including:

-Betamethasone dipropionate 0.05% - 50gm tube
-Triethanolamine Salicylate 10% - 100gm tube
-Mupirocin Ointment 2% - 15mg tube
-Triamcinolone Acetonide 0.1% - 7.5gm tube
-Fusidic Acid 2% - 15gm tube, 30gm tube
-Terbinafine Hcl 1% - 30gm tube
-Betamethasone Valerate 0.05% 50gm jar, 30gm jar
-Clothrimazole 1% - 30gm jar

-Ketoconazole 2% - 30gm tube
-Lotriderm Cream 1/0.05% - 15 gm jar
-Mipirocin Calcium 2% - 30gm tube
-Mometasone Furoate 0.1% - 50gm tube
-Clothrimaderm Cream with 1% HC Powder - 50gm jar
-Clotrimazole 1% - 7 jars of different sizes
-Betaderm 0.05% with 1/2% Ment and 1/2% Camp - 60gm
-Dovobet Ointment - 60gm tube
-Amcinonide Ointment 0.1% - 60gm
-Polysporin 30gm tube
-Bactroban 30 gm tube
-Hydrocortisone 1% - 45gm jar

On April 29, 2015, during interviews with PSWs #104 and #131, they indicated that they have access to the Treatment Room as the prescribed topical creams they apply to residents are stored in that room. Housekeeping Aide #132, indicated she accessed the Treatment Room daily to clean it, as it was part of the daily cleaning routine.

During an interview with the Director of Care(DOC) on April 29 and 30, 2015, she indicated that the Treatment Room was accessible to all staff, including the denturist and the dental hygienist. She indicated that the prescribed topical creams would be stored in the Medication Room immediately, an area restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 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 areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg 79/10 s. 131 (5) in that the home did not ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On April 27, 2015 Inspector #573 observed four prescribed topical creams in Resident #18's room in a plastic 3-drawer chest at the end of the resident's bed.

On April 28, 2015 and April 29, 2015 Inspector #545 observed five prescribed topical creams in the top drawer of a plastic 3-drawer chest at the end of Resident #18's bed.

Upon review of Resident #18's health record, approval by the prescriber for self-administration of all the prescribed topical creams observed at the resident's bedside was not found.

On April 29, 2015, Resident #18 indicated to the Inspector that he/she applied the creams some of the time and that the PSWs applied the creams as well. The resident indicated that he/she wanted the prescribed creams at the bedside for convenience.

On April 29, 2015 the Director of Care (DOC) confirmed that Resident #18 did not have approval from the prescriber to self-administer prescribed topical creams. The DOC removed all prescribed topical creams from the resident's room and indicated she would be addressing this issue with the physician and staff. [s. 131. (5)]

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 no resident administers drugs to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: 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 comply with O.Reg 79/10 s. 8 (1) (b) in that the home did not ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

In according with O. Reg. 79/10, s. 114 (2), the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

The home's Policy: Handling Hazardous Medications, Policy Number 7.12, dated July 2014 was reviewed. On page 1 of 7, a non-cytotoxic hazardous drug is defined as "drugs (other than cytotoxic drugs) that are deemed to have a reduced risk from occupational exposure, but where special handling precautions are required without special disposal precautions." On page 3 of 7 of the same policy, it is indicated that one (1) pair of Nitrile

Gloves should be worn when handling non-cytotoxic hazardous medications.

Resident #17's health record was reviewed and indicated that the resident was prescribed medications that require non-cytotoxic hazardous precautions and require registered staff to wear one pair of nitrile gloves when handling these medications.

On April 28, 2015 during the morning Medication Pass, Inspector #545 observed RN #100 handling non-cytotoxic medications wearing vinyl gloves. RN #100 indicated to the Inspector that she always used vinyl gloves when handling non-cytotoxic hazardous drugs for Resident #17 because she is not touching the medication, further indicating that she did not have access to nitrile gloves.

On April 28, 2015 RPN #108 indicated she did not have nitrile gloves on her medication cart, but thought some might be available on the West Medication Cart.

On April 28, 2015, the Director of Care (DOC) indicated that the home expects the registered staff to use non-cytotoxic hazardous precautions. The DOC further indicated that the home's pharmacy provider, Classic Care Pharmacy, provides the blue nitrile gloves. After searching for nitrile gloves in the home, the DOC indicated to the Inspector that one box of nitrile gloves were found in the Treatment Room as they were used by the dental hygienist and the denturist and/or dentist. Later that day, the DOC indicated that she had placed nitrile gloves in both Medication Carts and ordered a case of nitrile gloves immediately, and further indicated that a memo would be sent to all registered staff to review the home's policy regarding Handling Hazardous Medications to ensure they comply with their policy. [s. 8. (1) (b)]

2. The home's policy: Administering and Documenting Controlled Substance, Policy Number 4.3, dated July 2014 was reviewed by Inspector #545. Under the section Procedure, it was documented as such:

1. Locate the Resident's MAR sheet, individual count sheet and controlled substance medication. Each controlled substance medication is individually inspected and verified for correctness against the Resident's MAR sheet, verifying the "eight rights"

2. The dose of the controlled substance medication is documented, recording the:
a) Date and time
b) Administered quantity
c) Remaining quantity

d) Signature of administering person

3. The controlled substance medication is administered to the Resident, as ordered

4. The controlled substance medication is initialed as administered, on the MAR, in the correct box, immediately after administering and before the next Resident is medicated

Upon review of Resident #17's health record, it was noted that a controlled substance medication was ordered twice daily. In the Medication Administration Record, times of administration were indicated as 08:30 and 16:30.

On April 28, 2015 at approximately 07:40, Inspector #545 observed the morning Medication Pass conducted by RN #100 with Resident #17. After administering different medications taken from different strip medication pouches, to Resident #17, the RN signed the electronic Medication Administration Record (eMAR) to indicate that all medications were given. The inspector did not observe the RN verify, prepare and administer the controlled substance.

Upon review of the eMAR, the medication was documented as administered by RN #S100 at 07:41. The Narcotic & Controlled Substance Binder available on the Medication Cart was reviewed by the inspector; on the individual count sheet for Resident #17, the following were not recorded for the morning dose of the specific controlled substance medication: a) date and time, b) administered quantity, c) remaining quantity, d) signature of administering person.

In the presence of RPN #S125 who was assigned to take over the Medication Pass just before 08:00 on April 28, 2015, Inspector #545 verified the double-locked Narcotic and Controlled Substance storage area located within the Medication Cart and observed Resident #17's morning dose of the controlled substance medication still in the blister pack.

The home's policy: Administering Routing Medications, Policy Number 4.2, dated July 2014 was reviewed. Under the section Procedure it stated:

1. Locate the Resident's MAR/TAR sheet and medication(s). Each medication is individually inspected and verified for correctness against the Resident's MAR/TAR sheet verifying the "Eight Rights"

2. The medication(s) are administered to the Resident as ordered

3. Each individual medication is initialed as administered, on the MAR/TAR, in the correct boxes (date/time), upon administration and before the next Resident's medication(s)

Resident #20 was prescribed a specific medication once daily to be administered at 08:30.

On April 28, 2015 at approximately 08:15, Inspector #545, accompanied by RPN #125, observed a medication in a "cut into" strip medication pouch in a pink plastic basket stored in a drawer in the Medication Cart.

Upon review of the eMAR for Resident #20, it was documented that RN #100 had administered the specific medication to Resident #20 at 07:35 on April 28, 2015. RPN #125 removed the medication from the strip medication pouch into a medication cup and administered it to Resident #20.

During an interview with the Director of Care (DOC) on April 20, 2015 she indicated that the registered staff were expected to follow the home's policy regarding administration of routine medications and controlled substance medications; further indicating that RN #S100 signed for the administration of medications to two residents in which medications were not administered as ordered. [s. 8. (1) (b)]

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 Resident #23 received 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 when she exhibited altered skin integrity.

Resident #23's health care record was reviewed and indicates the following:

On the evening shift of a specified day in September 2014, and into the night shift, PSWs reported to the registered staff that the resident had areas of reddened skin. The progress note indicates that barrier cream had been applied.

On the next day shift, Resident #23's skin was described as reddened and bleeding, and the progress note states that barrier cream had been applied.

On the day shift, two days after the initial report, Resident #23's areas of skin impairment were described as reddened and excoriated. The MD was contacted and a prescription cream was ordered.

The DOC was interviewed and stated that the home's instrument for skin and wound assessment was titled Skin/Wound Care Assessment and was located in the assessment section of Point Click Care (PCC). She stated that her expectation was that a member of the registered nursing staff would have completed a Skin/Wound Care Assessment in PCC when Resident #23's areas of skin impairment were reported. The DOC confirmed that a Skin/Wound Care Assessment was not completed.

[O-001029-14] [s. 50. (2) (b) (i)]

WN #9: 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 comply with O.Reg 79/10 s. 129 (1) (a) (i) in that the home did not ensure that that drugs are stored in an area or a medication cart, that is used exclusively for drugs and drug-related supplies.

On April 29, 2015 Inspector #545 observed the West Medication Cart which included a drug storage area used for narcotics and controlled substances. RPN #101 unlocked the narcotic and controlled substance storage area located in the bottom drawer of the locked Medication Cart, and the inspector observed:
-Two gold wedding bands taped to a small note indicating the rings were found in a specified room
-One gold wedding band inside a white envelop with a resident's name

In an interview with RPN #101 and RN #100 on April 29,2015, they indicated that registered staff used the narcotic and controlled substance storage area to store lost items and for safekeeping items such as jewelry and money. RN #100 indicated that items found on evenings or weekends, when the office is closed, are stored in the narcotic and controlled substance storage area until the families are contacted, but often if the items are not claimed, they are forgotten there. RPN #101 indicated that he was not aware that the Medication Cart, including the narcotic and controlled substance storage area should be used exclusively for drugs and drug-related supplies.

On April 29, 2015 during an interview with the Director of Care (DOC), she indicated that the wedding bands were removed from the narcotic and controlled substance storage area and that the home would be providing staff with separate storage area for lost items and safe keeping. [s. 129. (1) (a)]

Issued on this 8th day of May, 2015

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

Original report signed by the inspector.