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
Jan 19, 2015	2014_108110_0017	T-122-14	Resident Quality Inspection

Licensee/Titulaire de permis

REGIONAL MUNICIPALITY OF YORK
17250 Yonge Street NEWMARKET ON L3Y 6Z1

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

YORK REGION MAPLE HEALTH CENTRE
10424 Keele Street Maple ON L6A 2L1

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

DIANE BROWN (110), JUDITH HART (513), SUSAN SEMEREDY (501), VALERIE JOHNSTON (202)

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): December 17, 18, 22, 23, 24, 29, 30, 31, 2014 and January 2, 5, 6, 7, 2015.

The following complaint inspection was conducted with the Resident Quality Inspection (RQI):T-1280-14

During the course of the inspection, the inspector(s) spoke with administrator, director of care, food services supervisor, supervisor of care (SOC), acting supervisor of care, supervisor of programs and services, registered nurse (RN), physiotherapist (PT), professional practice lead, activationist, resident council assistant-administrative clerk, building maintenance worker, personal support workers (PSW), dietary staff, residents and families.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **10 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 10. Elevators

Specifically failed to comply with the following:

s. 10. (1) Every licensee of a long-term care home shall ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents. O. Reg. 79/10, s. 10 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents.
On an identified date, the inspector observed that the main elevators of the home are accessible to residents of the second floor and that these elevators can lead to the basement. In the basement there is access to an unlocked staff locker room and unlocked stairwells. Interview with the administrator revealed the home had a security audit completed in 2012 and that the home will be implementing recommendations in 2015. One of the improvements will include only allowing staff access to the basement. [s. 10. (1)]

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 any elevators in the home are equipped to restrict resident access to areas that are not to be accessed by residents, to be implemented voluntarily.

WN #2: 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 home is equipped with a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times.

The plan of care for resident #06 indicated that the resident is able to toilet on his/her own and is able to transfer with the use of mobility aides. On an identified date and time the call bell cord in the resident's washroom was found to be pulled tight from the wall mount and wrapped multiple times around the grab bar located on the left side of the toilet. The inspector pulled at the end of the call bell cord that would have been accessed by the resident if using the toilet, however, the call bell would not sound.

An identified PSW then tried to use resident #06's call bell from his/her washroom and was unable to activate the call bell and confirmed that the resident would not have been able to use it if needed. The PSW then un-wrapped the call bell cord and tried to activate the call bell again by pulling the cord forward from a sitting position while on the toilet and was still unable to activate the call bell. The PSW then tried to use the call bell again by reaching behind him/herself and pulling the cord down directly from the wall. The call bell activated and the PSW indicated that pulling the call bell cord directly down from the wall is generally the only way in which all resident bathroom call bells activate. The PSW further indicated that not all residents are physically and cognitively capable to reach and pull the call bell cord directly down from the wall in order to activate it.

The PSW indicated that all resident call bell cords located in all resident washrooms are long and have to be wrapped around the grab bar on one side of the toilet because the ends of the cord will hang down onto the floor potentially causing an infection prevention and control issue.

On an identified date and time, observations were conducted with the building maintenance worker of random resident rooms on an identified floor. The building maintenance worker confirmed that the bathroom call bell cords were observed wrapped around the grab bars beside the toilets and should not have been. The building maintenance worker indicated that once the call bell cord is wrapped around the grab bar the cord may not function properly. [s. 17. (1) (a)]

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 a resident-staff communication response system that can be easily seen, accessed, and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence.

Resident #51 is living with dementia and was identified by staff as incontinent of bowel and bladder.

Record review of the Minimum Data Set (MDS) identified the resident incontinent of stool and frequently incontinent of bladder.
The review of the bowel and bladder policy # NU-0505-01 and interview with registered staff responsible for the continence care program, confirmed that there was not a clinically appropriate tool specifically designed for assessment of incontinence to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions. [s. 51. (2) (a)]

The plan of care for resident #01, identified the resident as incontinent of both bowel and bladder requiring two staff assistance for continence care. Interviews with registered staff indicated that residents who are incontinent are only assessed to identify the type and size of continence care products to use. An interview with the SOC confirmed that the home currently does not have a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence, however, a clinically appropriate assessment tool is currently being developed corporately. [s. 51. (2) (a)]

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 there was a clinically appropriate tool specifically designed for assessment of incontinence to identify causal factors, patterns, type of incontinence and potential to restore function with specific interventions, to be implemented voluntarily.

WN #4: 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. (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 :

The licensee has failed to ensure that the written plan of care sets out clear directions to staff.

A review of resident #10's clinical records indicated that on an identified date, the resident was found on the floor in his/her bathroom. The resident was sent immediately to the hospital for further assessment and subsequently diagnosed requiring a surgical repair. The resident returned to the home. Staff interviews indicated that the resident is high risk for falls and as a result of his/her injuries sustained from the fall on the identified date, staff place floor mats on either side of the bed while the resident is in bed and

chair/bed alarms are attached to the resident. A review of the written plan of care for the resident directs staff to ensure that the resident's environment is clear of clutter, reinforce the need to call for assistance and that the resident is to wear proper non-slip footwear. An interview with a registered staff member indicated that the resident's written plan of care had not been updated when the resident returned to the home from hospital and confirmed that the plan of care does not provide clear directions to staff. [s. 6. (1) (c)]

Resident #10's plan of care identified the resident as having mild cognitive impairment and required daily cleaning of teeth or dentures by resident or staff. Interviews with direct care staff indicated that the resident has his/her own teeth and requires set up help and cueing from staff to clean his/her own teeth as he/she will forget. A review of the written plan of care for the resident does not include any direction to staff regarding the oral care that the resident requires on a daily basis. An interview with a registered staff member indicated that unless the staff member knew this resident, staff would not know what oral care was required by reading the written plan of care. The registered staff confirmed that the written plan of care for the resident does not provide any direction to staff regarding his/her oral care. [s. 6. (1) (c)]

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 an complement each other.

On an identified date, the inspector observed resident #42 being served a food item at lunch time in an identified dining room. This food item was not part of the planned menu or resident #42’s plan of care. An interview with the dietary aide revealed that he/she serves the resident this food item every day because his/her personal care giver always requests this item. An interview with the dietary supervisor confirmed that this decision should be verified, assessed and written as part of the resident's plan of care.
On the same day, during the same meal, the inspector observed resident #41 being served a texture modified sandwich which was changed to a lower textured meal. A review of the diet list revealed the resident is to receive the first textured diet offered. Interviews with a dietary aide, a PSW and a registered staff revealed that the resident’s diet texture had changed to the lower textured diet. A further review of the progress notes revealed the family had requested on an identified date, that the resident be served a textured diet. A dietary note to confirm the request was also identified. A few days later, record review revealed the family requested a lower textured diet for resident #42 however, there is no dietary follow up documented to this request. An interview with two

food service supervisors confirmed that the dietary department was not notified of the diet change and therefore did not document the resident's changed diet on the diet list for reference by staff serving in the dining room.
An interview with the food service supervisors confirmed that for residents #41 and #42 there had been a breakdown of communication and a lack of collaboration between the dietary and nursing departments in the development and implementation of the plan of care for these residents. [s. 6. (4) (b)]

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.

Record review for resident #62 indicated the physician ordered a medication to be administered three times a day with 40 ml of apple juice. The order was transcribed to the medication administration record as written.

On January 5, 2015, at 12:23 p.m. and January 6, 2015, at 12:30 p.m. resident #62 was observed to receive the medication with water and not with apple juice as prescribed. An interview with the RN charge nurse confirmed that it was practice to administer this resident's medications with water and not apple juice, therefore not providing the care specified in the plan of care. The RN reported that his/her recollection was that the apple juice was initiated for another medication and a new order will be requested to discontinue administration of the above medication with apple juice.

Record review for resident #62 indicated the physician ordered a medication to be administered three times a day before meals.
On January 5 and 6, 2015, resident #62 was observed to the medication after the resident completed the lunch meal. Interview with the RN charge nurse administering the medication reported that once seated in the dining room, resident #62 will refuse to leave the dining room to receive the pre-lunch medication. The RN charge nurse confirmed that care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

The licensee failed to ensure that residents are 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.

On December 22, 2014, resident #26's call bell was identified behind resident's headboard and not within reach while resident was in bed.

Record review and staff interviews identified that the resident's cognitive skills are severely impaired and the resident would not know to activate a call bell for staff assistance. Staff further revealed that they in turn, do frequent checks on resident #26 knowing he/she is unable to use the call bell for assistance.

Resident #26's written plan of care identified that the call bell should be within reach of the resident.

Resident #26's plan of care has not been reassessed and revised based on resident's cognitive skills and inability to activate the call bell for staff assistance. [s. 6. (10) (b)]

WN #5: 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 :

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system, that the licensee has instituted or put in place is in compliance with, implemented in accordance with all applicable requirements under the Act and is complied with.

On January 6, 2015, the first floor medication room was observed to have, in the government stock medication cabinet, expired products that included, two Nitrostat 0.6mg vials, lot #V112198 with expiry date of November 2014, and three Fleet Enemas, lot #1211698 with expiry date of March 2014.

Record review revealed that the pharmacy system index titled, Medication Storage and

Insulin Audit, index number 06-02-60, last updated and reviewed October 1, 2012, indicated under #14 that, no expired medications are retained in the medication room (unless awaiting disposal in a separate location) and under #16 that, discontinued (expired) medications are stored properly before disposal (separate from drugs for administration).

Interview with the RN and day charge nurse confirmed that the drugs were expired and were removed from the cabinet. Interview with the DOC confirmed that monthly audits are completed and the expired drugs should have been removed from circulation.

On January 6, 2015, one Epipen lot #3GU268 was observed in drawer #1 of the medication cart, with an expiry date of November 2014. Record review revealed that the Pharmacy System general Information, Continuous Quality Improvement Program, Medication Storage and Insulin audit, index number 06-01-10, last updated and reviewed October 1, 2012, indicated that all medications in the cart must be labeled and within expiry date.

Interview with the charge nurse confirmed that the Epipen had expired and was removed from the cart. Interview with the DOC confirmed that monthly audits are completed and the expired drugs should have been removed from circulation. [s. 8. (1)]

2. The home's policy Post Fall Assessment, dated January 2014, and Fall Prevention and Management Program 2013, require staff to initiate a referral to PT after each fall and for PT to complete a post fall assessment.

Resident #26 at high risk for falls and identified in the home's fall prevention management program had a fall on an identified date.
Record review and staff interview identified that a PT referral was not initiated and a PT assessment had not been completed related to resident #26's identified fall. [s. 8. (1) (a),s. 8. (1) (b)]

3. Resident #30 at high risk for falls and identified in the home's falls prevention management program had a fall on an identified date.
An interview with the RN who assessed the resident for injury post fall identified that a referral had not been sent to PT as required by the home's policy. An interview with the PT confirmed that a referral had not been received and an assessment had not been completed related to resident #30's identified fall.

The professional practice lead confirmed that PT referrals and assessments for residents #26 and #30 were not initiated as required by the home policy and program related to falls. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

The licensee has failed to ensure that the resident is dressed appropriately, suitable to the time of day and in accordance with his/her preferences, in his/her own clean clothing and appropriate clean footwear.

Resident # 27 receives total staff assistance for dressing and other activities of daily living as per the resident's plan of care. The resident ambulates with a walker, has been identified as a high risk for falls and wears hip protectors 24 hours a day.

On December 31, 2014, the inspector observed resident #27 to be wearing hip protectors , labeled with another resident's name. An interview with a PSW confirmed that the resident's clothing, hip protectors, did not belong to resident #27. [s. 40.]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in writing is provided within 10 days of receiving the Residents' Council advice related to concerns or recommendations

Interview with the president of the Resident Council revealed that the licensee does not respond in writing within 10 days of receiving Council's advice related to concerns and recommendations.
Record review and an interview with an appointed staff facilitator for the Resident Council confirmed that responses to concerns or recommendations are shared with the council at the next Resident Council meeting and not necessarily within 10 days of receiving the concern or recommendation. [s. 57. (2)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

An interview with the administrator and a review of the home's current process for determining satisfaction revealed that the home uses the standardized stage 1 questions from "Abaqis", a recognized quality of seniors' care questionnaire, plus two additional questions related to Resident Council.

Record review confirmed that the home's current survey is an audit. An interview with the administrator and a review of the survey revealed that the current process does not determine satisfaction with all programs and services in the home, such as physiotherapy , continence care, and the skin and wound program. [s. 85. (1)]

The licensee failed to ensure that the advice of Family Council is sought in developing and administration of the satisfaction survey and in acting on its results.
An interview with a Family Council representative and review of Family Council minutes revealed that the Council's advice was not requested in the development or carrying out of the satisfaction survey.
The administrator confirmed that there was no documentation to demonstrate that the licensee requested the advice of Family Council in the development and carrying out of the satisfaction survey. [s. 85. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
A response is made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

A review of the home's client complaint records indicated that on an identified date, the home received a written letter of concern from resident #31, regarding the care received by resident #21. An interview with resident #31 indicated that the SOC responded to his/her letter by indicating that his/her concerns had been addressed and he/she did not need to worry. Resident #31 indicated that he/she did not receive any information regarding the resolution of the complaint and indicated that the home may not have investigated the concern. The home's client complaint record and interviews with both the DOC and the SOC confirmed that the home investigated the concerns raised in the letter and provided a verbal response to resident #31 on an identified date. The documented response in the notes indicated that the home has followed up on his/her concerns but details cannot be shared with him/her due to confidentiality. The DOC and the SOC confirmed that the response did not include what the licensee had done to resolve the complaint, however expressed to the inspector what was done to resolve the complaint without disclosing personal health information. The DOC questioned whether this level of detail would be sufficient and indicated that the resident would be informed of the resolution. [s. 101. (1) 3.]

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 failed to ensure that drugs are stored in an area or a medication cart, which is used exclusively for drugs and drug-related supplies.

On January 6, 2015, the medication cart contents were observed to contain; one pencil case containing highlighter(s), money, hand cream, glasses, scissors, comb, 2 loose Q-Tips, mini light, one earring, one white hand mitt and in the locked, controlled medication compartment were several sets of dentures.

Interview with the charge nurse first floor confirmed that the above items did not constitute exclusive use of the medication cart for drugs and drug related supplies. [s. 129. (1) (a)]

Issued on this 28th day of January, 2015

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

Original report signed by the inspector.