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

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Original Public Report

Report Issue Date June 24, 2022
Inspection Number 2022_1423_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☒ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Chartwell Master Care LP

Long-Term Care Home and City
Chartwell Royal Oak LTCR, Kingsville

Lead Inspector
Cassandra Taylor (725)

Additional Inspector(s)
Ina Reynolds (524)

Also present during the inspection were inspectors;
Susan Crann (741069)
Marian Keith (741757)

Choose an item.
Cassandra L Taylor
2022.06.24 08:26:05
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INSPECTION SUMMARY

The inspection occurred on the following date(s): June 13-17, 2022.

The following intake(s) were inspected:

- Intake # 009367-22 (CIS # 2939-000014-22) – relating to falls prevention and management.
- Intake # 010383-22 (CIS # 2939-000016-22) – relating to falls prevention and management.
- Intake # 011021-22 (Complaint) – related to Nutrition and hydration, falls preventions and management and housekeeping.
- Intake # 007910-22 (Follow-up) related to CO#001 from inspection #2022_678577_0002 regarding s. 19. (1), CDD Apr 13, 2022

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007	s. 19 (1)	2022_678577_0002	#001	(#725)

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION SAFE STORAGE OF DRUGS

NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 138.(1)(a)(ii)

The licensee failed to ensure that medications were stored in a locked room or locked medication cart.

Rationale and Summary

During an observation on June 13, 2022, of the Mulberry unit it was noted that the medication room door was open. After further inspection it was noted to be broken and no locking mechanism was found. No residents or staff were present in the area at the time of observation. Medications and additional substances were noted in the unlocked cupboards of the unlocked medication room. The medications found in the cupboard were six different kinds of medications. The Assistant Director of Care (ADOC) #102 was asked to attend the medication room with the inspector. The ADOC #102 confirmed all medications and additional substances in the room should have been locked away. During the time with the ADOC #102 in the unlocked medication room, there was a red pencil case noted that contained a medication which was indicated by the ADOC #102 to be used for emergencies.

During an interview with the Environmental Services Manager (ESM) #112, it was indicated that the door lock broke on April 23, 2022, and staff breeched the door to access the medication cart in the room. The Director of Care (DOC) #101, confirmed they were aware of the incident and attended the home on the date of the incident. The DOC #101 indicated that they assisted in moving medications to another secure area which they used as a temporary medication room. The DOC #101 also indicated that the medications that were left in the room were locked in the cupboard. However, they forgot about the additional substances and indicated that the controlled substances should have been stored in the locked medication cart.

Review of the homes policies stated in part, "…A locked medication room for storage of medications is provided. Prescription medications are to be stored in locked medication carts."

"… the door to the medication room must be locked at all times.". Also, a policy for a specific kind of medication indicated; "… 9. Unless the resident has been assessed as capable of self-administering, the resident will be informed of any specific medicinal product the resident has will be stored in the locked medication cart.".

DOC #101 acknowledged the home had policies in place and they were not followed. Administrator #100 indicated they were unaware that the door had not been fixed and the broken door to the medication room was fixed within two hours of the inspector bringing it to managements attention.

Not keeping medications behind a locked door placed residents at a potential risk of accessing medications without staff awareness or that were not prescribed to them.

Sources: Observation of Mulberry, Staff interviews and the home's polices.

[#725]