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 Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Oct 29, 31, 2014 | 2014_235507_0018 | T-128-14 | Resident Quality Inspection |

**Licensee/Titulaire de permis**

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE ROUGE VALLEY
551 Conlins Road, TORONTO, ON, M1B-5S1

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

STELLA NG (507), JANICE PITTS (587), NATASHA JONES (591), TIINA TRALMAN (162)

**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): September 30, October 1, 2, 3, 6, 7, 8, 9, 10, 14 and 15, 2014.**

**The following Complaint Intakes were inspected concurrently with this Resident Quality Inspection (RQI): T-869-14, T-484-14, T-942-14 and T-791-13.**

**The following Critical Incident Intake was inspected concurrently with this Resident Quality Inspection (RQI): T-798-13.**

**During the course of the inspection, the inspector(s) spoke with administrator, director of care (DOC), assistant director of cares (ADOCs), registered dietitian (RD), program manager (PM), social worker (SW), maintenance manager (MM), RAI coordinator, registered staff, personal support workers (PSWs), restorative care aide, activity aides (AAs), housekeeping aide, residents, family members of residents.**

**During the course of the inspection, the inspector(s) observed residents' care, observed home environment including resident care areas, reviewed residents' records, reviewed the home's records.**

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

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

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home is a safe and secure environment for its residents.

Over the course of the inspection, the inspector observed the dirty utility room doors in four identified units unlocked. Staff members confirmed that the dirty utility room doors should be locked when not in use. [s. 5.]

2. On an identified date, the inspector observed the dirty utility room door in an identified unit, the laundry chute and the janitor's closet in another identified unit unlocked. The administrator and the maintenance manager (MM) were notified, and immediate actions were taken to lock the laundry chute room. [s. 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 the home is a safe and secure environment for its residents, to be implemented voluntarily.***

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**WN #2: 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.**

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**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 an identified date, on an identified unit, the inspector observed that an identified registered staff left the medication room with the medication cart and the medication room door unlocked when he/she went to check the residents' blood sugar in the dining room, and again when he/she went to administer the insulin to the resident.

On the same day, on another identified unit, the inspector observed that the medication room door was unlocked and no registered staff was present. The inspector located the identified registered staff down the corridor and he/she confirmed that he/she left the medication room door unlocked.

Interviews with the identified registered staff and an identified assistant director of care (ADOC) confirmed that the medication room door should be kept locked at all times when not in use. [s. 130. 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 all areas where drugs are stored are kept locked at all times, when not in use, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff**

**Specifically failed to comply with the following:**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**2. Skin and wound care. O. Reg. 79/10, s. 221 (1).**

**s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:**
**4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that all staff who provide direct care to residents receive skin and wound care training, as a condition of continuing to have contact with residents.

Record review and interview with the director of care (DOC) confirmed that 91.39 per cent of staff who provide direct care to residents did not receive training in skin and wound care in 2013. [s. 221. (1) 2.]

2. The licensee has failed to ensure that all staff who provide direct care to residents receive pain management, including pain recognition of specific and non-specific signs of pain, training, as a condition of continuing to have contact with residents.

Record review and interview with the administrator confirmed that 91 per cent of staff who provide direct care to residents did not receive training in pain management in 2013. [s. 221. (1) 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 all staff who provide direct care to residents receive training in skin and wound care and pain management, as a condition of continuing to have contact with residents, to be implemented voluntarily.***

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**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. (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. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident.

Record review of the physician's order for an identified resident, dated an identified date, indicated two side rails are to be used for safety while the resident is in bed. This order was not reflected in the plan of care.

Staff interviews with personal support worker (PSW), registered staff and an identified ADOC confirmed that the plan of care did not provide clear direction with regards to the resident's use of side rails. [s. 6. (1) (c)]

2. Interview with a second identified resident's family member revealed that the resident has been complaining of pain after sitting for a long period of time, and has brought to the attention of the home.

Interview with identified PSWs revealed that the resident is put to bed during the day and when requested. However, this is not included in the written plan of care for the resident.

Interviews with an identified registered staff and the DOC confirmed that the resident's rest routine is not supported by a plan care. [s. 6. (1) (c)]

3. Record review of the progress notes revealed and interviews with staff confirmed that a third identified resident spent most of his/her time in the room, and he/she did not want to be disturbed while in the room. Interviews with identified PSWs confirmed that the resident closed the door and put the yellow strap across the door when he/she was ready to go to bed at night, and the resident became aggressive if the door was opened by staff checking on him/her at night.

Record review revealed that on an identified date, a staff member found the resident lying face down on the floor in his/her room in the morning.

Review of the home's job routine for personal support worker/ health care aide for nights, updated November 28, 2008, states that visual rounds are to be done every hour for all residents.

Interviews with identified night PSWs confirmed that they did not open the third identified resident's door and checked during their shifts if the door was closed with the yellow strap across the door. Review of the resident's written plan of care revealed and interviews with staff confirmed that the resident's refusal to be checked was not reflected in his/her plan of care. Furthermore, there were no interventions to manage the resident's refusal to be checked. [s. 6. (1) (c)]

4. 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 revealed that the fourth identified resident is identified at high nutrition risk. The resident experienced slow unplanned weight change for a period of five months and the family declined nutrition intervention as resident's intake remained unchanged during this period. The resident continued to experience weight change of 8.0 per cent of body weight for the following three months.

On an identified date in the ninth month, the registered dietitian (RD) recommended nutrition intervention after meeting with the family. The recommendation was documented on the physician's order on the same day.

Interview with an identified registered staff revealed that he/she discovered that the physician's order had not been transcribed on to the e-medication administration record (e-MAR) until 13 days later when this was brought to his/her attention by the inspector. The registered staff corrected this oversight and the resident received the nutrition intervention on the same day. [s. 6. (7)]

5. The licensee has failed to ensure that the provision of the care set out in the plan of care is documented.

Record review revealed that the fifth identified resident developed two pressure ulcers within one week. Intervention to promote wound healing include turning and repositioning every two hours.

Record review of the resident's "documentation survey report" for a period of 13 months revealed that the above mentioned intervention were not documented as completed for the entire shift as follow:
- 1st month: 18 night shifts, 5 day shifts and 6 evening shifts,
- 2nd month: 23 night shifts, 21 day shifts and 15 evening shits,
- 3rd month: 20 night shifts, 14 day shifts and 11 evening shifts,
- 4th month: 21 night shifts, 17 day shifts and 12 evening shifts,
- 5th month: 23 night shifts, 19 day shifts and 14 evening shifts,
- 6th month: 24 night shifts, 12 day shifts and 9 evening shifts,
- 7th month: 19 night shifts, 18 day shifts and 11 evening shifts,
- 8th month: 23 night shifts, 24 day shifts and 21 evening shifts,
- 9th month: 30 night shifts, 12 day shifts and 29 evening shifts,
- 10th month: 30 night shifts, 14 day shifts and 25 evening shifts,
- 11th month: 23 night shifts, 8 day shifts and 25 evening shifts,

- 12th month: 3 night shifts, 3 day shifts and 13 evening shifts, and
- 13th month: 1 night shift, 5 day shifts and 10 evening shifts.

Interview with the DOC confirmed that the PSWs are responsible to document in the POC after turning and repositioning the resident. Care provided to the resident during the 13 months period was not documented consistently. [s. 6. (9) 1.]

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**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).**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that the home's pain management policy that the licensee is required by the Regulation to put in place is complied with.

An identified resident is identified at risk for complications and discomfort and on pain management. Review of the physician's order revealed that the resident is prescribed regular and prn analgesic for pain.

Review of the e-MAR revealed that the resident was given prn analgesic five times in one month, twice in the next month, and once in the following month.

Record review and interview with an identified registered staff confirmed that pain assessments were not completed for the resident after administering the above mentioned prn analgesic.

Review of the home's pain management policy, reference #RESI-10-03-01, effective date February 2014, and interview with an identified ADOC confirmed that pain assessment must be completed when a resident has experienced pain, including when a resident requesting a prn pain medication. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Skin and Wound Management Program has a policy that is in compliance with and is implemented in accordance with all applicable requirements under the Act.

Regulation section 50(2)(b)(iii) states that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds is assessed by a registered dietitian (RD) 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.

The home's policy titled "Skin Care", policy #03-01, dated June 2010, does not indicate that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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. This policy is not in accordance with the regulation section 50(2)(b)(iii). The DOC failed to provide any other policy of the home that satisfies the requirement under section 50(2)(b)(iii) of the Regulation. [s. 8. (1) (a),s. 8. (1) (b)]

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails**

**Specifically failed to comply with the following:**

**s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,**
**(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).**
**(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).**
**(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that where bed rails are used, the resident's bed system has been evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

An identified resident's written plan of care indicates a handrail is to be used to assist with positioning in bed. Physicians order dated on an identified date, indicates one side rail is used for safety while in bed. Interview with identified staff confirmed that one side rail is used while the resident is in bed.

The home provided the inspector with a bed rail entrapment assessment record. The assessment indicated most of the beds on two identified units were assessed, however, the identified resident's bed was not assessed. Interview with the MM confirmed that the resident's bed had not been evaluated to minimize risk to the resident. [s. 15. (1) (a)]

**WN #7: 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 and response system that, can be easily seen, accessed and used by residents, staff and visitors at all times.

On an identified date, the inspector observed the call bell by an identified resident's bed not functioning, and a staff member was notified.

On the following day, the inspector observed the call bell by another identified resident's bed not functioning. Staff members were notified of the non-functioning call bell.

On the third day, the inspector observed the above mentioned call bells functioning.

On the first above mentioned identified date, the inspector observed a third identified resident in bed. The call bell was on the floor, and out of reach by the resident.

Interview with the identified PSW confirmed that call bell should be placed within the resident's reach. The PSW then attached the call bell to the pillow, so that the resident can reach the call bell. [s. 17. (1) (a)]

**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 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.

Record review revealed that an excoriated area was noted on an identified resident's body on an identified date. The pressure ulcer was assessed as stage II three weeks later and stage III 10 weeks after the excoriated area was noted.

Record review revealed and interview with the RD confirmed that the resident was not referred to him/her for assessment until four months after the excoriated area was noted, and the assessment by the RD was not completed until two days after the referral was made. [s.50 (2) (b) (iii)]

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

Record review revealed that the above identified resident developed a stage I pressure ulcer on an identified date, and was assessed as stage II one week later. Another stage II pressure ulcer also developed on the same day, and both pressure ulcers are not healed 15 months later.

Record review and interviews with registered staff and the DOC confirmed that weekly skin assessments on the resident's two pressure ulcers were not conducted consistently during the 15 months' period.

Review of the progress notes and weekly wound care record of the resident revealed that skin assessments were completed as follow:
- 1st month: twice,
- 2nd month: three times,
- 3rd month: twice,
- 4th month: once,
- 5th month: once,
- 6th month: three times,
- 7th month: three times,
- 8th month: three times,
- 9th month: three times,
- 10th month: three times,
- 11th month: once,
- 12th month: three times,
- 13th month: once,
- 14th month: once, and
- 15th month: twice.

Furthermore, only one of the two pressure ulcers was assessed in the above mentioned skin assessments. [s. 50. (2) (b) (iv)]

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

**Specifically failed to comply with the following:**

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Record review revealed that an identified resident receives analgesic PRN for pain management.

Record review revealed that the resident received an analgesic for pain on three identified dates in a three weeks' period. The resident was not assessed using a clinically appropriate assessment instrument during this period.

Interviews with an identified registered staff and the DOC confirmed that a pain assessment using a clinically appropriate assessment was not carried out for the resident as required. [s. 52. (2)]

**WN #10: 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 respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

A review of the Resident Council minutes in a six months' period revealed that there was no date of response indicated on the written response to Resident Council. The administrator could not confirm that the response was written within 10 days of receiving Residents' Council advice related to concerns or recommendations. [s. 57. (2)]

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**WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 60. Powers of Family Council**

**Specifically failed to comply with the following:**

**s. 60. (2) If the Family Council has advised the licensee of concerns or recommendations under either paragraph 8 or 9 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Family Council in writing. 2007, c. 8, s. 60. (2).**

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**Findings/Faits saillants :**

1. The licensee has failed to respond in writing within 10 days of receiving Family Council's advice related to concerns or recommendation.

Record review revealed and interviews with staff confirmed that concerns raised during the Family Council meetings on three identified dates were responded verbally during meetings.

An interview with the administrator confirmed that the Family Council was not provided with a response in writing within 10 days for the concerns raised during the above mention meetings. [s. 60. (2)]

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**WN #12: 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. (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 has failed to seek the advice of the Residents' Council in acting on the 2013 satisfaction survey results.

Interview with the administrator confirmed that the home has not sought the advice of the Residents' Council in acting on the results of an identified year's satisfaction survey result. [s. 85. (3)]

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**WN #13: 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 is used exclusively for drugs and drug-related supplies.

On an identified date, the inspector observed the following items stored in the medication cart on an identified unit:
- 2 unlabelled insulin pens of a resident who no longer resided in the home
- the narcotic bin contained jewellery, eye glasses, power cord, an envelope containing one 5 dollar bill, 2 VISA credit cards and a bank card
- residents' change purse with several coins.

Interviews with the identified registered staff and the ADOC confirmed that the above mentioned items should not be kept in the medication cart, and that the medication cart is to be used exclusively for drugs and drug-related supplies [s. 129. (1) (a)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

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**Findings/Faits saillants :**

1. The licensee has failed to ensure that when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

An identified resident is identified at risk for complications and discomfort and on pain management. Review of the physician's order revealed that the resident is prescribed regular and prn analgesic for pain.

Review of the e-MAR revealed that the resident was given the prn analgesic five times in one month, twice in the following month, and once in each of another two months.

Record review and interview with the identified registered staff confirmed that the resident's response and the effectiveness of the above mentioned analgesic were not monitored nor documented as required. [s. 134. (a)]

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**Issued on this 5th day of November, 2014**

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