Ontario

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

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

Hamilton District
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Original Public Report

Report Issue Date: May 24, 2023	
Inspection Number: 2023-1204-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: Hamilton Continuing Care, Hamilton	
Lead Inspector Karlee Zwierschke (740732)	**Inspector Digital Signature** Karlee Zwierschke Digitally signed by Karlee Zwierschke Date: 2023.06.13 14:23:51 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 8-11, 17, 2023

The following intake(s) were inspected:

- Intake: #00003066 (critical incident) and Intake: #00005940 (critical incident) related to staff to resident physical abuse.
- Intake: #00016874 (critical incident) related to a missing resident.
- Intake: #00022639 (complaint) related to staffing qualifications.

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

Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 148 (1) (a)

The licensee failed to ensure that the home's policies and procedures on drug destruction were followed, specifically where staff were required to destroy and dispose of expired drugs.

In accordance with O.Reg 246/22, s. 11 (1) (b) the licensee is required to ensure the home has in place a policy that provides for ongoing identification, destruction, and disposal of expired drugs, and that it must be complied with.

Specifically, staff did not comply with Section 21 of the Policies & Procedures: Manual for MediSystem serviced homes, updated in April 2021.

Rationale and Summary:
On May 11, 2023, inspector found a box of medication in the first floor medication room that had expired April 2023. The homes procedure for drug destruction indicated that all expired medication should be destroyed and disposed of. Registered Practical Nurse (RPN) confirmed that the medication was expired and disposed the medication.

Sources: observations, interview with RPN, Policies & Procedures: Manual for MediSystem serviced homes (updated April 2021) section 21.
[740732]

Date Remedy Implemented: May 11, 2023

WRITTEN NOTIFICATION: Prevention of Abuse and Neglect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to ensure that a resident was protected from physical abuse by a staff member on an identified date.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

Rationale and Summary
On an identified date, a staff member was attempting to provide personal care to a resident who was resisting. The staff member did not let go of the resident's hand and the resident pulled away from the PSW. The resident suffered an injury as a result of the interaction.

Sources: resident's clinical record, interview with staff member and general manager, investigation notes for the CI. [740732]

WRITTEN NOTIFICATION: Certification of Nurses

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 51

The licensee failed to ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario.

Rationale and Summary
On an identified date, an agency RPN came to the home for a RPN shift. A search was conducted on the College of Nurses of Ontario (CNO) website "Find a Nurse" which revealed that the RPN did not have an active registration with the CNO at that time. The Assistant Director of Nursing Care (ADNC) confirmed that the RPN was not entitled to practice as an RPN and was sent home once the home became aware.

Not ensuring that all staff who performed duties as a registered practical nurse had a current registration put residents at risk of possible medication errors.

Sources: interview with ADNC, investigation notes, college of nurses of Ontario website. [740732]

WRITTEN NOTIFICATION: Security of Drug Supply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 139 3.

The licensee failed to ensure that a monthly audit of the daily count sheets of controlled substances was completed.

Rationale and Summary:
Monthly audits were missing for January and February of 2023 on the "Monthly Narcotic and Controlled Substances Audit of Count Sheets" for all three floors in the home and for April 2023 for third floor.

By not ensuring the monthly narcotic audits were completed, gaps in the narcotic supply may not have been identified

Sources: record review, interview with ADNC. [740732]