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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Feb 22, 2017	2017_393606_0001	015120-16	Resident Quality Inspection

Licensee/Titulaire de permis

ORILLIA LONG TERM CARE CENTRE INC.
689 YONGE STREET MIDLAND ON L4R 2E1

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

LEACOCK CARE CENTRE
25 MUSEUM DRIVE ORILLIA ON L3V 7T9

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

JANET GROUX (606), DEREGE GEDA (645), JOVAIRIA AWAN (648)

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): January 4, 5, 6, 9, 10, 11, 12, 13, 16, 17, and 18, 2017.

The following intakes were inspected concurrently with the RQI:
Three Follow up Orders regarding resident abuse.
Two Complaint regarding resident abuse, and regarding improper care and medication administration issues.
Three Critical Incidents (CI) regarding a medication error, and missing narcotic.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (CDOC), Education Coordinator (EC), Life Enrichment Coordinator, Registered Dietitian (RD), Food Service Supervisor (FSS), Pharmacist, Physician, Physician Aide, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeping Aide (HA), Residents, and Substitute Decision Makers (SDM).

During the course of the inspection, the inspectors conducted observations of residents and home areas, medication administration, infection control prevention and practices, reviewed clinical health records, staffing schedules/assignments, a Family Council (FC) questionnaire, meeting minutes of the Residents' Council, relevant committee meetings, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **5 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #003	2016_333577_0008	645
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #002	2016_333577_0008	645
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2016_333577_0008	645

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a written plan of care for each resident that sets out the planned care for the resident.

Review of an identified CI in 2016 indicated that an identified medication had been applied on an identified date and was reported missing two days later.

Review of resident #006's Electronic Medication Administration Record (e-MAR) for an identified month in 2016 indicated a physician's order that indicated the times and doses the identified medication were to be administered.

Review of resident #006's progress notes indicated documentation that the identified medication was missing on an identified date and time.

Interview with RN #123 revealed he/she was the staff member who observed the identified medication missing and indicated the resident may have contributed to his/her medication to go missing due to the resident's identified skin condition and/or behaviour. The RN stated that the plan of care indicates the registered staff to initiate an identified intervention to secure the medication in place.

Review of resident #006's MARs for two identified months in 2016 did not include the identified intervention as mentioned above.

Interview with the DOC revealed the home completed an investigation and stated the missing medication was never located. He/she stated to prevent another incident from occurring, the resident's MARs should have been updated to include for the registered staff to initiate an identified intervention to keep the medication secure.

The home has failed to ensure there is a written plan of care for resident #006 that sets out the planned care for the resident.

2. Review of the home's resident manual for Plan of Care, effective September 19, 2013, indicated the plan of care shall be reviewed and revised when the resident's care needs change. The policy further stated that the plan of care would be based on an interdisciplinary assessment with respect to the resident for skin conditions including altered skin integrity.

Review of resident #004's plan of care identified he/she returned from the hospital on an identified date and was assessed for a skin integrity impairment that he/she acquired from the hospital. The resident was hospitalized again on an identified date and returned 19 days later. On the day the resident returned from the hospital, a head to toe assessment was completed and identified the resident had skin integrity impairment on two identified areas of his/her body.

Review of resident #004's electronic Treatment Medication Administration (eTAR) on an identified month in 2016, identified interventions to treat the skin integrity impairment but was initiated nine days after the second time the resident had returned from the hospital on an identified date. Further review indicated the registered staff provided the identified intervention to treat the skin integrity impairment for nine days in the absence of an eTAR.

Interview with the DOC and RN #125, the lead for the home's Skin Care Program, reported residents with skin integrity impairments were to be assessed and the complimentary skin care interventions were to be initiated on the eTAR by the registered staff immediately after a skin integrity impairment was identified.

3. Review of a complaint received by the Ministry of Health and Long Term Care

(MOHLTC) on an identified date reported an allegation of improper care and medication administration for resident #010.

Review of resident #010's admission progress notes on an identified date revealed the resident indicated his/her preferences regarding the administration of his/her identified medication.

Review of resident #010's plan of care on an identified date did not indicate the resident's preferences with regards to the administration of the identified medication as indicated during the admission meeting on an identified date.

Interviews with resident #010 and his/her SDM revealed they had informed the home during the admission meeting about his/her needs and preferences and gave specific directions on the need for the identified medication to be given based on his needs and preferences. The SDM stated that resident #010 has an identified medical condition that requires the identified medication to be given as directed to avoid an exacerbation of the symptoms of the identified medical condition and place the resident at risk.

Interview with RN #126 revealed he/she was informed of resident's #010's needs and preferences regarding the administration of the resident's medication during the admission meeting and he/she was certain that the resident's preferences as indicated above were included in the plan of care. The RN stated it is the home's policy to include a resident's needs and preferences in the resident's plan of care.

Interview with the DOC confirmed the home's practice is to ensure that a resident's preferences are indicated in the plan of care.

The home failed to ensure that the plan of care was based on resident's #010's needs and preferences with regards to his/her medication.

4. Review of an identified CI and date reported a medication error involving resident #007 who received an identified scheduled medication, twice on an identified date and time.

Review of an identified 2016 e-MAR of resident #007 indicated the resident is to be administered an identified medication at an identified time.

Review of resident #007's progress notes on an identified date and time indicated RN

#122 discovered after administering the identified medication to resident #007, that RN #121 had already administered the same medication to the resident earlier.

The inspector attempted to contact RN #122 for an interview but was unsuccessful as the RN not available.

Interview with RN #121 revealed at the start of the identified date, he/she poured one tablet of the identified medication in a medication cup and stated he/she did not administer the medication to the resident at that time because he/she went to reassess resident #020. The RN stated that he/she returned to the medication room shortly after assessing resident #020 and retrieved the identified medication from resident #007's medication bin and administered it to the resident at approximately an identified time and indicated he/she did not sign the e-MAR. He/she further revealed RN #122 was assigned to the unit to take over the medication pass while he/she provided care to resident #020, and did not tell RN #122 that he/she had already administered the identified medication to resident #007.

Interview with the DOC confirmed it is the home's expectation for registered staff to sign the e-mar right after they administer a medication to a resident and RN #121 failed to document this.

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 there is a written plan of care for each resident that sets out the planned care for the resident,
-to ensure that the plan of care was based on the resident's needs and preferences and;
-to ensure that the provision of care is documented, to be implemented voluntarily.

WN #2: 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 ensure that 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, was complied with.

Review of an identified complaint reported an allegation of improper care and medication administration for resident #010.

Review of an identified MAR for resident #010's indicated a physician's order for registered staff to administer an identified medication at an identified dose and time.

Interview with resident #010 and the SDM alleged that on an identified date the resident's identified medication scheduled to be administered at an identified time was not administered to resident #010 until an identified time. They alleged RN#112 who was responsible to administer the resident's medication went on his/her break prior to the identified time which resulted in resident #010 to receive his/her medication late. The SDM indicated it was important for staff to be aware that when the resident does not receive his/her identified medication as scheduled it can exacerbate and cause identified symptoms of the resident's medical condition and place resident #010 to be at risk.

Interview with RN #112 revealed he/she recalled the incident on the identified date and indicated the home's guideline for medication administration permitted the registered staff to administer a medication one before or after the medication is to be administered and confirmed he/she gave the medication late on the identified date.

Interview with the DOC confirmed the home's guideline for medication administration permits a registered staff to administer a medication one hour before or after the

medication is scheduled.

The licensee has failed to ensure that their guideline was followed.

2. Review of the home's policy entitled, "Residents Rights, Care and Services-Medication Management-Narcotics and Controlled Substances, Section: Medication Management System, Revised date: October 7, 2013, indicated that "a count of all narcotics shall be completed by the off going and on coming Registered Staff member at change of shift, and whenever an exchange of medication keys takes place".

Review of an identified and date, reported a medication error involving resident #007 who received his/her identified scheduled medication, twice on an identified date and time.

Review of resident #007's progress notes on an identified date and time indicated, RN #122 discovered after administering the identified medication to resident #007, RN #121 had already administered the same medication to the resident earlier.

The inspector attempted to contact RN #122 for an interview but was unsuccessful as the RN was not available.

Interview with RN #121 revealed he/she requested assistance from RN #122 to help him/her administer the medications on an identified date because he/she had to attend to resident #020 who had a change in his/her condition. The RN confirmed that it is the home's practice that a count of all the narcotics must be completed, prior to exchanging the medication keys and confirmed he/she and RN #122 did not follow this this procedure.

Interview with the DOC confirmed the homes policy required a count of all narcotics prior to the exchanging medication keys between registered staff. The DOC confirmed from the home's investigation, the policy was not followed.

3. Review of an identified CI and date reported that during a medication narcotic count on an identified shift and time, the registered staff discovered an identified medication missing.

Review of the home's policy entitled, "Residents Rights, Care, and Services-Medication Management-Narcotics and Controlled Substances, Section: Medication Management

System revised date October 7, 2013, stated:
-discontinued narcotics shall be processed for drug destruction immediately;
-upon discontinuation of a narcotic, identify as discontinued on the narcotic/inventory record along with the date and signature of the Registered Staff member discontinuing the narcotic. The remaining blank spaces are crossed out. The discontinued narcotic must be secured under double lock in a permanently affixed cabinet with the medication room/cart, until the time of drug destruction by the pharmacist and Registered Staff member.

Review of resident #008's LTC Controlled Substance Administration Record with an identified treatment number indicated the identified medication was discontinued and removed on an identified date, two days after the physician ordered it to be discontinued. It indicated the resident's LTC Controlled Substance Administration Record with an identified treatment number was being used by the registered staff to administer resident's identified medication on two identified dates and time, two days after it was discontinued.

A review of resident #008's LTC Controlled Substance Administration Record and an identified blister card, blister card A, indicated RN #119 administered the resident's identified medication on an identified date time from blister card rather than from another identified blister card, and he/she had signed for it. The record also indicated RN #104 also administered the resident's identified medication from an identified blister card on an identified date and time rather than from another identified blister card and he/she had signed for it.

Interview with RN #119 revealed he/she had counted with the night nurse on the identified date and shift, and revealed there were two blister cards for resident #008 in the narcotic bin, blister card A containing six of the identified medication tablets, and blister card B containing the five and a half of the identified tablets. The RN indicated blister card A should have been removed from the narcotic bin when blister card B arrived from the pharmacy on the identified date. He/she indicated rather than taking the identified medication from blister card B, he/she took the identified medication tablet from blister card A and stated that he/she was sure only "pushing" out an identified amount of the tablet of the identified medication. He/she confirmed that at the narcotic shift count on the identified shift and time, blister card A's count was four instead of five and a half tablets of the identified medication and confirmed this was a discrepancy in the narcotic count.

Interview with RN #120 revealed he/she counted at the identified time with RN #119 and confirmed that the identified medication was missing an identified amount of the tablet from blister card A and confirmed that there was a discrepancy in the narcotic count.

Interview with the DOC revealed the home's investigation could not determine how the identified medication went missing and stated the identified medication tablet was never located. He/she stated the home concluded that proper procedures for medication administration and narcotic handling were not followed.

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 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, is complied with, to be implemented voluntarily.

WN #3: 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff.

Review of resident #005's plan of care identified he/she presented with an identified skin integrity impairment to an identified area of his/her body.

Review of resident #005's progress notes and assessments identified missing skin assessments for 12 identified dates in 2016.

Interview with RN #104 stated registered staff were responsible for ensuring weekly skin assessments are completed. The RN reported if a weekly skin assessment was not completed on the shift that it was scheduled, the registered staff on the oncoming shift would be made aware through staff communication, and would be responsible for completing the weekly skin assessment. Review of the identified dates with RN #104 during the interview confirmed weekly skin assessments had not been completed for resident #005's identified skin integrity impairment on an identified area of his/her body.

Review of the dates identified for resident #005 with the DOC and RN #125, the lead for the home's Skin and Wound Program, reiterated the homes policy and expectation for

the completion of weekly skin assessments for residents presenting with altered skin integrity. The DOC and RN #125 lead confirmed resident #005 was not assessed weekly for his/her skin integrity impairment. The DOC further confirmed that the home's policy had not been followed.

2. Review of an identified written plan of care of resident #005 included a focus identifying that he/she presented with an identified skin integrity impairment to an identified area of his/her body.

A review of resident #005's clinical records indicated that the resident's identified an identified skin integrity impairment to an identified area of his/her body and had not been assessed using a clinical assessment tool for skin assessment 12 identified dates in 2016.

Interview with RN #104 stated registered staff were responsible for ensuring weekly skin assessments are completed. The RN reported if a weekly skin assessment was not completed on the shift that it was scheduled, the registered staff on the oncoming shift would be made aware through staff communication, and would be responsible for completing the weekly skin assessment. Review of the identified dates with RN #104 during the interview confirmed that on the above mentioned dates, resident #005's identified skin integrity impairment had not been assessed by registered staff as required.

Review of the dates identified for resident #005 with the DOC and RN #125, the lead for the home's Skin and Wound Program, reiterated the homes policy and expectation for the completion of weekly skin assessments for residents presenting with altered skin integrity. The DOC and RN #125 lead confirmed resident #005 was not assessed weekly for his/her skin integrity impairment on the identified dates in 2016.

3. Review of resident #004's clinical records identified he/she presented with multiple identified skin integrity impairments located on identified areas of his/her body. A review of resident #004's progress notes for the past 12 months identified only three dates in 2016 an assessment had been completed for three of the resident's identified skin integrity impairments. The progress notes did not indicate any other assessments were completed for the above identified skin integrity impairments.

Review of resident #004's clinical records identified he/she had a number of identified

skin integrity impairments located on identified areas of his/her body. The records indicated 12 skin care assessments in 2016 were missing.

Interview with RPN #111 stated that registered staff were responsible for ensuring weekly skin assessments are completed for each individual skin impairment a resident may present with. Review of the identified dates with the RN during the interview confirmed weekly skin assessments had not been completed for resident #004's individual identified skin integrity impairments.

Review of the dates identified for resident #004 with the DOC and RN #125, the lead for the home's Skin and Wound Program reiterated the home's policy and expectation for the completion of weekly skin assessments for residents presenting with altered skin integrity. The DOC and RN #125 confirmed that weekly skin assessments had not been completed consistently for resident #004's identified skin integrity impairments.

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, to be implemented voluntarily.

WN #4: 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:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
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 :

1. 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 was dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Review of a complaint received on an identified date by the MOHLTC reported an allegation of improper care and medication administration for resident #010.

Interview with resident #010 and his/her SMD revealed they had approached RN #112 on an identified date in 2016, about the resident not receiving his/her medication on time.

Interview with RN #112 revealed he/she recalled the incident and confirmed the SDM had approached him/her and was very concerned that resident #010 received his/her identified medication late on an identified date in 2016. RN #112 stated he/she informed the SDM that the home's policy indicates the registered staff are able to give a medication one hour before or after it is scheduled. He/she indicated on the identified date was the only time he/she did not give the medication time. RN #112 revealed he/she did not initiate any follow up to the SDM's concern.

Interview with the DOC revealed the home did not receive any information regarding issues with resident #010's medication administration of his/her identified medication until an identified date in 2016 when the resident and the SDM met with him/her and the other management staff to verbalize their concerns about resident #010's medication administration of his/her identified medication. The DOC stated the home followed up on the issue to ensure an incident as mentioned above does not happen again.

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 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: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately, 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 a monthly audit had been 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 were discovered.

Review of the home's monthly audits entitled, "Narcotic and Controlled Substance Audit Form" for between identified dates in 2015 and 2016, revealed missing and/or incomplete audits for 14 identified months in 2015 and 2016.

Interview with the DOC indicated that the home's practice was two members of the nursing staff were to complete the audits of the narcotic and controlled substances in the five home units and stated this had not been completed for the above mentioned months.

The home failed to ensure that a monthly audit had been undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action was taken if any discrepancies were discovered. [s. 130. 3.]

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 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, to be implemented voluntarily.

Issued on this 23rd day of February, 2017

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

Original report signed by the inspector.