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
May 26, 2017	2017_535557_0004	020079-16, 031432-16, 033754-16, 034276-16, 035468-16, 004137-17, 004365-17, 005451-17, 007431-17, 007914-17, 009203-17	Critical Incident System

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

VALERIE PIMENTEL (557)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): April 24, 25, 26, 27, 28, May 1, 2, 4, 8, 9, 10, 11, 12 and 15, 2017.

The following Critical Incidents were inspected concurrently:
Log #009203-17, Log #035468-16, Log #004365-17, Log #005451-17, and Log #007914-17 related to medications.
Log #034276-16 and Log #031-432-16 related to alleged staff to resident abuse, and Log #020079-16 related to alleged visitor to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Education Coordinator (EC), Resident and Family Care Worker (RFCW), Life Enrichment Coordinator (LEC), Staffing Coordinator (SC), Administration Assistant (AA), Registered Nurse(s) (RN), Registered Practical Nurse(s) (RPN), Personal Support Workers (PSW), Private Duty PSW (PDPSW), and Resident(s).

During the course of the inspection, the inspector conducted observations of residents and home areas, staff and resident interactions, provision of care, medication management system, reviewed clinical health records, staffing schedules/assignments, minutes of relevant committee meetings and relevant policy and procedures.

The following Inspection Protocols were used during this inspection:
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **5 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. 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 any plan, policy, protocol, procedure, strategy or system that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with.

Record review of the home's policy titled "Resident Rights, Care and Services "Medication Management - Narcotics and Controlled Substances", Revised Date: 2013-10-07, identified the registered staff are to retain individual narcotic count sheets and record all narcotics administered.

A second policy was reviewed from Silver Fox Pharmacy entitled "Documentation and Storage of Medication - Controlled Substance Documentation", Policy # 5.3, Dated: November 2016, identified the registered staff are to document on the CSAR the date and time, quantity administered, remaining quantity and signature of person administering the medication. The policy further states the nurse will document after the medication is administered before moving to the next resident.

As part of the Critical Incident System inspection, the inspector reviewed the Narcotics and Controlled Substances, Medication Management System related to missing medications.

On an identified date and time in 2017, the inspector and an identified registered staff member observed and reviewed the blister packs containing medications with the Controlled Substance Administration Record (CSAR) and observed the following missed documentation on the CSAR's:
-Resident one: an identified medication had incomplete documentation on the CSAR. The time, date, amount administered, amount wasted and amount remaining was not

documented.
-Resident two and six: an identified medication had incomplete documentation on the CSAR. The time, amount administered, amount wasted and amount remaining was not documented.
-Resident three: an identified medication had incomplete documentation on the CSAR. This medication was administered twice this shift and the time, amount administered, amount wasted and amount remaining was not documented.
-Resident four: an identified medication had incomplete documentation on the CSAR. The time, date, amount administered, amount wasted, amount remaining and signature was not documented.
-Resident five: an identified medication had incomplete documentation on the CSAR. An identified registered staff member completed the documentation in the presence of the inspector for this resident.

Record review of the electronic medication administration record (eMAR) and the shift count records for the above resident's and the identified medications were accurate and corresponded with the CSAR's.

An interview with an identified registered staff member confirmed he/she knew they were to complete the documentation on the CSAR at the time of the administration as per the home's policy but acknowledged he/she did not sign the CSAR during the identified medication pass. He/she further stated he/she had administered the above noted medications to the identified resident's.

An interview with the director of care (DOC) confirmed it is the home's expectation that all registered nursing staff complete the documentation at the time of administering the residents' medications to include the time, date, amount administered, amount wasted, amount remaining and signature of the nurse. The DOC acknowledged that the home's policies on Narcotics and Controlled Substances and Controlled Substance Documentation was not complied with.

2. Record review of the home's policy titled "Resident Rights, Care and Services - Medication Management - Drug Storage", Revised Date: 2013-10-07, identified that all drugs are to be stored in a safe and secure area where the access is restricted to the registered staff.

A second policy was reviewed from Silver Fox Pharmacy policy titled "Documentation and Storage of Medication - Safe Storage of Medication", Policy # 5.1, Dated: November

2016, identified that all medications must be stored in a locked medication room.

On an identified date and time in 2017, inspector #618 observed a white plastic bin containing prescription ointments sitting on the counter in the unlocked team station in an identified home area. Inspector #557 followed up with the identified registered staff member who confirmed the identified prescription ointments as not being secured and locked:
-Resident one: an identified prescription ointment,
-Resident two: an identified prescription ointment,
-Resident three: two identified external prescriptions,
-Resident four: an identified prescription ointment, and
-Resident five: an identified prescription ointment.

On a second identified date and time in 2017, inspector #557 and Co-Director of Care (Co-DOC) observed two pink unlocked tackle boxes containing prescription ointments sitting on top of a linen cart in another identified home area.

An interview with the identified registered staff member and Co-DOC confirmed they knew the prescription ointments are to be locked in the medication room when not being used as per the home's policy but acknowledged they did not lock the prescription ointments away in the medication room.

An interview with the DOC confirmed the team station was not locked on the identified home area and the two pink tackle boxes on top of the linen cart in the other identified home area were not secured, both areas could be accessed by anyone and it is the home's expectation that all registered nursing staff are to ensure the prescription ointments are locked in the medication room when not being used. The DOC acknowledged that the home's policies on Safe Storage of Medication was not complied with.

3. Record review of the home's policy titled "Resident Rights, Care and Services "Medication Management - Administration of Medications", Revised Date: 2015-07-24, identified that all medications are to be properly labeled.

A second policy was reviewed from Silver Fox Pharmacy policy titled "Documentation and Storage of Medication - Safe Storage of Medication", Policy # 5.1, Dated: November 2016, under topic "Storage of Removed Medications", identified that all medications with illegible labels are to be removed and when the physician discontinues a medication it is

to be removed.

On an identified date and time in 2017, the inspector and an identified registered staff member in an identified home area reviewed the following prescription ointments found in the white plastic bin. The following prescription ointments or external prescription were identified and confirmed as being discontinued and or had an illegible label and remained in the white plastic bin:
-Resident one: an identified prescription ointment was ordered on an identified date in 2017, for 14 days.
-Resident two: an identified prescription ointment was ordered on an identified date in 2017, for 14 days.
-Resident three: an identified prescription ointment was ordered on an identified date in 2017, for 14 days. Had a second external prescription that was opened on an identified day in 2010, and was to be discarded in an identified month in 2010. The discard actual date was illegible and was from the year 2010.
-Resident four: an identified prescription ointment was ordered on an identified date in 2017, for 14 days.
-Resident five: had a prescription label on an identified government pharmacy supplied ointment, which was illegible and the ointment had expired on an identified day and month in 2017. This ointment had not be reordered on the three month drug review, dated in and identified month in 2017, or removed from the bin.

An interview with identified registered staff member confirmed that resident one, two, three and four's prescription ointments were discontinued and had remained in the identified white plastic bin. He/she also confirmed that resident three and five had illegible labels.

An interview with the DOC confirmed when medications are discontinued and labels are not legible they are to be removed. He/she confirmed it is the home's expectation that all registered nursing staff ensure that when prescriptions ointments are discontinued or labels are illegible they must be removed from stock. The DOC acknowledged that the home's policies on Safe Storage of Medication and Administration of Medications was not complied with.

4. Record review of Silver Fox Pharmacy policy titled "Documentation and Storage of Medication - Safe Storage of Medication", Policy # 5.1, Dated: November 2016, identified that all medications should remain in the original container until administered to the resident.

On an identified date in 2017, in an identified time frame, the inspector and DOC observed in an identified medication room, three plastic medication cups containing medication. The medication cups had no identifiers on them and were unlabeled sitting on top of the medication cart. These medications were pre-poured and did not remain in their original blister packs or medication sleeve until they were to be administered as follows:
Cup one - contained two tablets of an identified medication
Cup two - contained one tablet of an identified medication, and
Cup three- contained one tablet of an identified medication, the contents in these three cups were identified by a registered staff member who poured the medications. He/she further confirmed which resident they belonged too.

An interview with an identified registered staff member confirmed he/she had pre-poured the medication and was able to identify the medication and whom it belonged too. He/she indicated when he/she was going to administer the medication to one of the identified resident's, the resident refused and he/she chose to keep the medication on top of the cart until the resident would accept the medication. He/she did not have any reason as to why the medication for the other two residents were sitting on top of the medication cart.

An interview with the DOC confirmed that the identified registered staff member had pre-poured the three identified resident's medication and that the medication did not remain in the original blister packs or medication sleeve until the administration of medication, as he/she was present at the time of the observation. The DOC acknowledged that the home's policies on Safe Storage of Medication was not complied with

5. Record review of the home's policy titled "Resident Rights, Care and Services "Medication Management - Administration of Medications", Revised Date: 2015-07-24, identified that the registered staff will stay with the resident until the medication is taken.

On an identified date and time in 2017, the inspector observed in an identified home area, a plastic medication cup containing a liquid medication. The medication cup was sitting on a feeding table outside of the dining room. The identified resident had left his/her liquid medication sitting on the table.

An interview with two identified registered staff members confirmed neither of them had stayed with the identified resident until he/she had taken his/her medication. One of the identified registered staff members had confirmed that there was a specific amount of

milliliters (mls) of the identified medication in the plastic medication cup. The second registered staff member confirmed he/she should not have left the liquid medication unsupervised and should have waited until the resident consumed the medication.

An interview with the DOC confirmed that identified registered staff member should not have left the identified resident's medication on the table and that he/she should have remained with the resident until the medication was taken. The DOC acknowledged that the home's policies on Administration of Medication was not complied with.

6. The home submitted a critical incident (CI) to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in 2017, reporting that an identified resident's medication was missing at an identified time.

Record review of the home's policy titled "Resident Rights, Care and Services", "Medication Management - Medication Errors', Revised Date: 2013-10-07, identified the registered staff will document in the progress notes the residents status, actions taken and further follow up action to be taken.

Record review of the progress notes for the identified date in 2017, revealed the registered staff did not document the status of the resident, actions taken and any further follow up action that needed to be taken.

An interview with the identified registered staff member confirmed he/she did not document any assessment of the resident or actions taken in the progress notes.

An interview with the DOC confirmed that identified registered staff member should have documented the medication incident in the identified resident's progress notes including any assessment, action taken and further follow up actions required. The DOC acknowledged that the home's policies on Medication Errors was not complied with.

7. The home submitted a CI, to the MOHLTC, on an identified date in 2016, reporting an allegation of visitor to resident abuse.

Record review of the home's policy titled "Resident Rights, Care and Services - Abuse", Revised Date: 2015-03-26, identified the staff will assess the resident's condition, evaluate for safety, emotional and physical well-being of the resident. The incident will be documented including a resident assessment, their condition, all conversations with the resident, the SDM, attending or on call physician, police, Administrator and DOC had

been notified at the time on the resident's medical record. The policy also identified to initiate an investigation checklist.

Record review of the identified resident's plan of care for an identified day in 2016, revealed the following:
Three entries were found in the progress notes for the resident and identified the following:
-At a specific time, the resident went out with an identified visitor, the resident's lunch was saved in the fridge,
-A second entry identified the resident returned with the identified visitor at a specific time.
-The third entry identified the Resident and Family Care Worker (RFCW) and Life Enrichment Coordinator (LEC) held a conference call with substitute decision maker (SDM) to discuss concerns related to the resident's visitor.
-Under the Risk tab the home did not complete a risk assessment,
-Under the Assessment tab the home did not complete a head to toe assessment, and
-Release of Responsibility for Leave of Absence form identified the visitor signed the resident out at specified time and returned at the identified time.

An interview with the DOC confirmed there was no injury to the identified resident. He/she confirmed he/she had spoken to the resident the following day and second time the following week and there were no ill effects to the resident. The DOC confirmed there was no documentation in the resident's plan of care to confirm the resident had an assessment completed, that their condition was stable, that the physician, police, Administrator or DOC had been notified at the time. He/she confirmed the home did not initiate an investigation checklist. The DOC acknowledged that the home's policy for abuse was not complied with. [s. 8. (1) (b)]

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 policy that the licensee is required by the Act or Regulation to have instituted or otherwise put in place was complied with:
- registered nursing staff complete documentation at the time of administering the residents' narcotic and controlled substance medication to include the time, date, amount administered, amount wasted, amount remaining and signature of the nurse,
- registered nursing staff are to ensure that prescription ointments are locked in the medication room when not being used,
- registered nursing staff ensure that when prescriptions ointments are discontinued or labels are illegible they must be removed from stock and or replaced,
- registered nursing staff ensure that all medications remain in the original blister packs or container until the administration of medication to the resident,
- registered nursing staff are to remain with the resident until the medications are taken,
- registered nursing staff document medication incidents in resident progress notes including any assessment, action taken and further follow up actions required, and
- registered nursing staff document in the residents medical record after an allegation of abuse the following: assessment of the resident's condition, evaluate for safety, emotional and physical well-being of the resident, all conversations with the resident, the SDM, attending or on-call physician police, Administrator and DOC. The home is to initiate an investigation checklist, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

On an identified date and time in 2017, the inspector and the DOC observed in the medication room in an identified home area, three plastic medication cups containing medication. The medication cups had no identifiers on them and were unlabeled sitting on top of the medication cart. These medications had been pre-poured and did not remain in their original blister packs until they were to be administered to the identified residents.

An interview with identified registered staff member confirmed he/she had pre-poured the following medications and was able to identify what was in the medication cups and identified which resident it belonged to:
Cup one - contained two tablets of an identified medication and
Cup two - contained one tablet of an identified medication, and
Cup three- contained one tablet of an identified medication, the contents in these three cups were identified by a registered staff member who poured the medications. He/she further confirmed which resident they belonged too.

When asked why he/she pre-poured the medication, he/she indicated when he/she went to administer the medication to one of the identified resident, the resident refused and he/she chose to keep it on top of the cart until the resident would accept the medication. He/she did not have any reason as to why the medication for the other two resident's was sitting on top of the medication cart.

An interview with the DOC confirmed the identified registered staff member had pre-poured the three identified resident's medication and that the medication did not remain in the original blister packs or medication sleeve until the administration of medication, as he/she was present at the time of the observation. [s. 126.]

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #3: 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 secure and locked.

On an identified date in 2017, inspector #618 observed a white plastic bin containing prescription ointments sitting on the counter in the unlocked team station in an identified home area. Inspector #557 followed up with the identified registered staff member they observed residents in the area or near the team station.

The following prescription ointments were identified and confirmed with the identified

registered staff member as not being secured and locked:
-Resident one: two identified prescription ointments, and
-Resident two: an identified prescription ointment.
These three prescriptions were observed in the identified white plastic bin and were not secured or locked.

On May 15, 2017, inspector #557 observed two pink tackle boxes containing prescription ointments sitting on top of an unsupervised linen cart in an identified hallway. Residents were ambulating in the vicinity and no staff were observed.

An interview at the time of observation with Co-DOC confirmed these two pink tackle boxes containing prescription ointments were sitting on top of an unsupervised linen cart were not secure and that the prescription ointments when not in use must be secured and locked away in the cupboard.

An interview with the DOC confirmed the team station was not locked and could be accessed by anyone. He/she also confirmed that prescription ointments were not stored in an areas that were secured and locked in either home areas as observed by the Co-DOC and inspectors. [s. 129. (1) (a)]

2. The licensee has failed to ensure that 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.

On an identified date in 2017, the inspector and the DOC entered the locked medication room in an identified home area. The inspector and the DOC observed three plastic medication cups sitting on top of the medication cart with no identifiers. An identified registered staff member entered the medication room.

The inspector asked the identified registered staff member what was in the medication cups. He/she identified the following:
Cup #1, #2 and #3 belonged to specific identified resident's and he/she confirmed what medication was in each cup and identified what time the medication was to be administered. He/she further identified that cups one and two contained a type of controlled substance. When asked if they were secured and double locked, his/her response was no and further explained when he/she went to administer the medications one resident refused and that he/she would attempt to administer the medication later. He/she indicated that the medications should be double locked.

An interview with the DOC confirmed that the controlled substances were not secured and double locked. [s. 129. (1) (b)]

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 drugs are stored in an area or a medication cart that is secure and locked, and
- to ensure that 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, to be implemented voluntarily.

WN #4: 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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use.

On an identified date in 2017, the inspector observed on four occasions during an identified medication pass on an identified home area in a 30 minute time frame the medication cart left unlocked. An identified registered staff member after preparing a medication for a resident would walk away into the dining room or down a hallway of the home area and leave the medication cart unlocked. The inspector observed the medication cart to ensure that no resident, staff member or visitor could compromise the security of the drug supply contained within the medication cart.

An interview with identified registered staff member confirmed he/she did walk away and leave the medication cart unlocked.

An interview with the DOC confirmed that it is an expectation that the medication cart be locked at all times when registered staff are not in attendance of the cart. [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 steps are taken to ensure the security of the drug supply, including the following: All areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

The home submitted a CI, to the MOHLTC, on an identified day in 2016, reporting that a resident‘s medication went missing.

Record review of the plan of care for the identified resident revealed the following:
- The physician orders confirmed the resident was to receive an identified medication at an identified time interval.
- The progress notes and the identified the medication went missing on an identified day in 2016, during an identified time frame.
- The eMAR confirmed that an identified registered staff member checked and signed the eMAR that the medication was present.

The identified registered staff member documented during an identified time frame at two hour intervals to see the progress notes. The progress notes confirmed the medication was missing on two identified days in 2016.

On the third identified day in 2016, the progress notes and eMAR confirmed the medciation was applied at an identified hour.

An interview with identified registered staff member confirmed the medication was missing on the two identified days in 2016, and had not been replaced when it went missing.

An interview with the DOC confirmed the registered staff did not follow the directions of the physician to ensure that the identified resident received their medication as prescribed. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 3. A missing or unaccounted for controlled substance.

The home submitted a CI, to the MOHLTC on an identified day in 2017, the home identified the resident's identified medication went missing on an identified day in 2017. The MOHLTC after hour's pager was not notified.

Record review of the identified resident's eMAR and the LTC CSAR confirmed on an identified day in 2017, at two identified time frames the resident received his/her medication, a controlled substance. The Controlled Substance Shift Count record (CSSCR) count on the identified day in 2017, at an identified time was accurate identifying 20 tablets of the medication. At shift count the CSSC record identified there were 17 tablets. There was a one tablet of the identified medication missing.

Interview with the DOC indicated that this was an identified long week-end and did not realize the report was submitted late. An interview with the DOC confirmed the home did not submit a Critical Incident to the Director within one business day. [s. 107. (3) 3.]

Issued on this 31st day of May, 2017

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

Original report signed by the inspector.