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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2015	2015_377502_0015	T-1698-15	Resident Quality Inspection

Licensee/Titulaire de permis

2063414 ONTARIO LIMITED AS GENERAL PARTNER OF 2063414 INVESTMENT LP
302 Town Centre Blvd., Suite #200 TORONTO ON L3R 0E8

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

Fountain View Care Community
1800 O'Connor Drive East York ON M4A 1W7

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

JULIENNE NGONLOGA (502), GORDANA KRSTEVSKA (600), JOANNE ZAHUR (589), JULIET MANDERSON-GRAY (607), SOFIA DASILVA (567), TILDA HUI (512)

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): July 20, 22, 23, 24, 27, 28, 29, 30, August 4, 5, and 6, 2015.

During the course of the inspection, the inspector(s) spoke with the Executive Director, director of care (DOC), assistant director of care (ADOC), registered nursing staff, personal support workers (PSWs), food services supervisor, registered dietitian (RD), dietary aides, physiotherapist (PT), physiotherapist aide (PTA), resident care relation coordinator, environmental service staff, housekeeping staff, Schedule Coordinator residents, substitute decision makers (SDMs) and family members of residents.

The inspectors also conducted a tour of the resident home areas, observations of medication administration, staff and resident interactions, provision of care, dining services, record review of resident and home records, meeting minutes for Residents' Council and Family Council, menus, staff training records, staffing schedules and relevant policies and procedures

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

14 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it.

Review of the most recent written plan of care revealed resident #012 was usually continent of bladder and can use toilet independently. The resident had an identified condition and required one staff to provide assistance for a specified care activity. Resident #012 also exhibited responsive behavior toward co-residents.

On a specified date and time, the inspector observed resident #012 going to the washroom without assistance, while an identified staff assigned to the resident was observed sitting at the nursing station.

Interview with the identified staff revealed he/she was directed to provide specified care activity because the resident had responsive behaviour. The staff stated he/she was unaware of the plan of care and interventions related to continence care set out for the resident and did not have access to resident's plan of care since his/her return to work three months prior the inspection.

Interview with the scheduling coordinator confirmed the identified staff returned to work

three months prior the inspection, and had been providing direct care to the resident. He/she also confirmed the identified staff's access to the resident's electronic plan of care was not activated upon his/her return, then proceed to activate his/her access to the the resident's electronic plan of care. [s. 6. (8)]

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident’s care needs change or care set out in the plan is no longer necessary.

Interview with resident #015 on an identified date revealed the resident had altered skin integrity. The resident indicated he/she was asked to stay in the room for the day due to the alteration in skin integrity.

Review of the most recent written plan of care revealed nursing staff documented on a specified date, the resident had altered skin integrity. There was no goals and interventions set up to address the issue of the alteration in skin integrity in the written plan of care.

Interview with an identified nursing staff confirmed the resident was thought to have the above identified skin problem. The service contractor was brought in to check and determined the resident did not have the above identified problem. Orders for specified medication were obtained from the attending physician. However, the written plan of care was not revised to reflect the change in the resident's care needs and the current treatment regime for the resident's altered skin integrity. [s. 6. (10) (b)]

3. Record review of the most recent plan of care revealed that staff should administer a specified medication as needed (PRN) to resident #008. Record review of the medication administration record (MAR) did not provide evidence that the resident was taking any specified medication. Record review of the physician order for a specified date, revealed there was an order to discontinue the above identified medication.

Interview with an identified nursing staff revealed the plan of care was not updated to reflect the changes in medication. Interview with the DOC confirmed the plan of care should be updated when there was significant change in resident status. [s. 6. (10) (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:
- staff and others who provide direct care to a resident are kept aware of the contents of the plan of care and have convenient and immediate access to it, and
- the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, 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 any policy and procedure put in place was complied with.

Record review of the home’s "Medications Management – Drug destruction" Policy #V3-930, revised April 2013, revealed the following medications will be identified, destroyed and disposed:
A) expired medications,
B) medications with illegible labels,
C) medications that are not labelled appropriate such as unlabelled or in containers with worn, damaged, incomplete or missing labels, and
D) medications that are no longer required due to being discontinued, or when the resident is discharge or deceased.

On a specified date and times, the inspector observed identified medications with past expiry dates for residents #033, #034 and #32 stored in medication cart.

Interview with identified nursing staff confirmed the medications were expired. Interview with both identified nursing staff and ADOC confirmed the home’s policy required the medications to be removed from the medication's cart and reordered when expired. [s. 8. (1) (b)]

2. Review of the home’s “Lifts and Transfers- Resident Care” policy #V3-850, revised March 2012, and the ”Pre-Startup Checklist” revealed that all staff, prior to using the mechanical lifting device for transfer or repositioning shall obtain the appropriate sling for the use with the mechanical lift, correct sling size and type for the resident as identified in the resident’s plan of care.

Record review of the progress notes revealed on identified date #021 had a fall with specified injury and was transferred to the hospital. Review of the home investigation record revealed identified staff used a sling which was bigger than the appropriate sling.

Interview with identified staff and DOC confirmed the staff did not check to ensure the sling was appropriate to transfer the resident as specified in the home's policy. [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 and procedure put in place was complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director.

Interview with resident #006 revealed an identified staff was rude to him/her. The resident stated when he/she asked the identified PSW to hand him/her any item, such as a towel or an article of clothing, the staff just throws the item to him/her. During the meal service, according to the resident, the identified staff also made comments about him/her with respect to the resident eating ice cream and then having to go to the washroom afterward. The resident also stated the identified staff left him/her in distress in bed after morning care as retaliation, because he/she had reported the identified staff to the management staff.

Review of the home's investigation record revealed on identified date, resident #006 complained about the above identified staff. The investigation record revealed the identified staff had provided care to the resident in a rough manner and left him/her in a distressed state.

Interview with the identified staff indicated the resident was able to adjust the head of the bed independently. The staff stated he/she did not ensure the resident bed was functioning after morning care and before he/she left the resident unattended and went to call for assistance with transfer. The identified staff confirmed when he/she came back the resident was in distress, but did not leave the resident in that state intentionally.

Interview with an identified maintenance staff indicated the resident was not able to adjust the head of bed, because the bed was not plugged into the electrical outlet. Interview with the DOC confirmed he/she conducted the alleged abuse investigation immediately following the resident's complaint, but did not report the suspicion to the Director. [s. 24. (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 the person who had reasonable grounds to suspect that improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm has occurred, immediately report the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Review of the progress notes and home's investigation notes revealed on an identified date, resident #012 slid out of the sling and struck his/her back of the head on the floor while being transferred back to bed with the hoyer lift by two identified staff. The resident had an identified symptom and was transferred to the hospital.

Interviews with identified staff confirmed the resident had his/her own sling, but they had instead, used the toilet sling which was bigger size and the resident slid out and hit his/her head.

Interview with the DOC confirmed the identified staff had used a bigger size sling that was not safe to transfer the resident from the wheelchair to the bed. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #5: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Record review revealed resident #002 had a specified treatment order. Record review of the weekly skin assessment record for specified dates, could not locate a weekly skin assessment was done for the above mentioned skin integrity.

Interview with an identified nursing staff revealed the resident had an altered skin integrity and confirmed a weekly skin assessment was not completed for the above mentioned area. Interview with the ADOC also confirmed a weekly skin assessment was not done for the above mentioned area. [s. 50. (2) (b) (iv)]

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the equipment are maintained in a safe condition and in a good state of repair.

On July 20, 2015, at 12:15 p.m., the inspector observed the wires of the electrical cord on a Hoyer lift located on the second floor exposed, the cord's rubber was peeled off. This was brought to the maintenance staff's attention.

Interview with an identified maintenance staff confirmed the wires were exposed on the hand control of the Hoyer lift. He/she also indicated the lift was locked out, tagged out and removed from the floor because it was not safe to use after the inspector brought the concern forward. [s. 15. (2) (c)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her SDM, if any, within six weeks of the admission of the resident.

Interview with resident #004's SDM indicated he/she had not been invited to any care conference of the interdisciplinary team since the resident was admitted in the home two months prior the inspection.

Review of the resident's plan of care and the home care conference records could not locate any documentation to indicate resident #004 and his/her SDM have been invited or participated in a care conference since his/her admission in the home.

Interview with the resident care coordinator confirmed resident #004 and his/her SDM had not been invited to the 6-weeks post admission care conference; however an annual care conference was scheduled on September 17, 2015. [s. 27. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living included is in the residents' plan of care.

On an identified dates, the inspector observed resident #011's wheelchair was tilted while sitting in the television (TV) and activation (AR) rooms respectively.

Record review of the most recent plan of care revealed on an identified date, resident #011 had a new wheelchair. The resident was seen by the occupational therapist (OT), however, no documentation was available related to the use of the resident's wheelchair as a PASD.

Interview with an identified Physiotherapist Assistant (PTA) confirmed the resident's wheelchair was to be tilted when he/she was sitting in the TV room or participating in activities for safety. Interview with an identified nursing staff confirmed staff are directed to tilt the resident wheelchair for comfort, and position the resident upright during meals. He/she also confirmed information was not included in the resident's plan of care. Interview with the DOC confirmed resident #011's wheelchair was used as a PASD and staff should include that in the plan of care. [s. 33. (3)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence.

Review of the most recent written plan of care revealed resident #012 was usually continent of bladder and can use toilet independently. The resident had an identified condition and required one staff to provide extensive assistance with specified care after the toilet use. Resident #012 also exhibited responsive behavior toward co-residents.

On a specified date and time, the inspector observed resident #012 going to the washroom without assistance, while an identified staff assigned to the resident was observed sitting at the nursing station.

Interview with the identified staff revealed he/she was directed to provide specified monitoring because the resident had responsive behaviour. The staff stated he/she was unaware of the plan of care and interventions related to continence care set out for the resident and did not have access to resident's plan of care since his/her return to work three months prior the inspection.

Interview with an identified nursing staff confirmed resident #012 was usually continent of bladder and can toilet independently but required extensive assistance with the above specified care after each toilet use by one staff. [s. 51. (2) (c)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:

1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

1. The licensee has failed to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month
2. A change of 7.5 per cent of body weight, or more, over three months.

Review of resident #005's weight history for specified period of time, revealed the resident had involuntary weight change.

Review of the resident's written plan of care revealed no assessment was completed for the resident following the above identified weight loss by the RD.

Interview with an identified nursing staff confirmed the resident had a significant weight change but a referral was not sent to the RD. Interview with the RD confirmed he/she did not assess the resident because resident #005 was not referred to him/her following the above mentioned weight change. [s. 69. 1.,s. 69. 2.,s. 69. 3.,s. 69. 4.]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an organized preventive pest control program using the services of a licensed pest controller was in place at the home, including records indicating the dates of visits and actions taken.

Interview with an identified maintenance staff revealed the home had a process that whenever pests are discovered at the home, staff are to enter the details of the pest sighting into the "Pest Sightings & Reporting Log" form. Maintenance staff will then call in the pest control service provider to come in to examine and exterminate any identified pest. At the completion of the visit, the technician of the pest control service contractor will provide a report with the date of visit and actions taken. All reports from the pest control service provider are filed in a binder kept at the maintenance department.

review of the pest control visit records revealed there was no evidence of documented reports with visit dates and/or actions taken for several identified dates of reported pest activity.

Interview with the identified maintenance staff confirmed there were no documented record of any visits made by the contract service provider for the above identified pests. [s. 88. (1)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated lead for the housekeeping and laundry services programs.

Interview with the housekeeping supervisor revealed the home's environmental services manager (ESM) had left his/her position three months prior to the inspection. Since the departure of the ESM, there had been no staff designated to lead the housekeeping and laundry services. The housekeeping supervisor indicated he/she was not the designated lead of the housekeeping services.

Interview with the DOC confirmed there had been no staff designated to be the lead for the housekeeping and laundry services since April 2015. [s. 92.]

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 specified date, the inspector observed a wallet stored in the narcotic bin with medications for residents #039 and #040 in a medication cart.

Interviews with identified nursing staff confirmed the wallets should not be stored in the medications cart and they were not sure why they were there. Interview with an identified ADOC confirmed it was the home's expectation items that are not used for medication purposes should not be stored in the medications cart. [s. 129. (1) (a)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:

1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
- The date the drug is received in the home
- The signature of the person acknowledging receipt of the drug on behalf of the home

Review of the home’s "Drug Record Book" for an identified unit revealed medications were shipped to the home for 11 residents on identified dated. Review of the packing slips for the above mentioned dates revealed there were no recording of the date the identified drugs were received or a signature of the person acknowledging receipt of the medications.

Interview with identified nursing staff and ADOC confirmed the packing slips should have been signed and included the dates the medications were received. [s. 133.]

Issued on this 4th day of November, 2015

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

Original report signed by the inspector.