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

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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_543561_0002	001408-17	Resident Quality Inspection

Licensee/Titulaire de permis

THE REGIONAL MUNICIPALITY OF PEEL
10 PEEL CENTRE DRIVE BRAMPTON ON L6T 4B9

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

SHERIDAN VILLA
2460 TRUSCOTT DRIVE MISSISSAUGA ON L5J 3Z8

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

DARIA TRZOS (561), HEATHER PRESTON (640), NATASHA JONES (591), SAMANTHA DIPIERO (619)

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 18, 19, 20, 23, 24, 25, 26, 27, 30, and 31, 2017.

The following concurrent inspections were completed with the Resident Quality Inspection (RQI):
Follow Up Inspection:
004117-16 - abuse

Critical Incident Inspections:
018403-16 - alleged resident to resident altercation
025818-16 - alleged staff to resident verbal abuse
012328-16 - falls
028183-16 - falls
035495-16 - falls

Complaint Inspections:
000252-16 - alleged physical, emotional abuse, and neglect
019221-16 - alleged resident to resident abuse
020273-16 - alleged resident to resident abuse
002422-17 - falls
025669-16 - unknown cause of a fracture
030171-16 - equipment causing a possible safety concern

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Supervisors of Care (SOC), Resident Assessment Instrument (RAI) Specialist, Program Support Nurse, Social Worker, Facilities Services Supervisor, Maintenance Supervisor, Activation and Volunteer Services Supervisor, Registered Dietitian, Registered Staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), President of the Residents' Council, President of the Family Council, housekeeping staff, residents and family members.

During the course of the inspection, the inspectors toured the home, observed the provision of care, reviewed health care records, and reviewed relevant policies, procedures and practices.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **6 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 #001	2015_275536_0022	561

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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 failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A) Resident #012 was admitted to the home on an identified date in 2016. The Minimum Data Set (MDS) Admission Assessment assessed the resident as usually continent of bowel and frequently incontinent for bladder. The Bowel and Bladder Assessment completed on admission indicated the resident was only incontinent of bladder during the night with functional urinary incontinence. The Restorative Continence assessment completed on admission assessed the resident at low potential of restorative continence. The admission written plan of care identified a focus of "incontinent of bladder" with a goal of "will remain continent of bladder". Interview with the Resident Assessment Instrument (RAI) Specialist, confirmed the assessments of the resident were confusing,

not consistent and did not complement each other. Interview with the Director of Care (DOC) confirmed the continence assessments for resident #012 was not consistent, integrated and did not complement each other.

B) Resident #021 was admitted to the home on an identified date in 2016. The Admission MDS assessment indicated the resident was continent of bowel and occasionally incontinent for bladder. The first Bowel and Bladder assessment completed after admission indicated the resident to have urinary incontinence of entire contents of bladder, one to two times daily with bowel continence of normal. The Restorative assessment completed on admission indicated the resident was frequently incontinent of bladder and continent of bowel. The Nursing admission assessment indicated the resident was independent and continent of bowel and bladder.
The admission plan of care stated the resident was continent of bowel and bladder but required assistance to maintain.
Interview with the RAI Specialist, confirmed the assessments of the resident were confusing, not consistent and did not complement each other. Interview with the DOC confirmed the continence assessments for resident #021 was not consistent, integrated and did not complement each other. [s. 6. (4) (a)]

2. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

On an identified date in 2015, resident #026's Substitute Decision Maker (SDM) spoke with PSW #128 and registered staff #129 in person, in relation to the status of resident #026's health condition. Interview with the SDM indicated that both staff members indicated that the resident was in good health, with no new changes. During their visit the SDM became aware of resident #026's altered skin condition. Interview with PSW #128 indicated that they were aware of the resident's altered skin integrity and had informed registered staff #129 of these changes and did not inform resident #026's SDM of the skin issue until asked by the SDM. Interview with registered staff #129 indicated that they did not inform the SDM about resident #026's altered skin condition when the SDM asked about the resident and confirmed that they spoke to the SDM about the altered skin integrity when the SDM called the home at specified hour. Interview with SOC #115 confirmed that the PSW and registered staff members did not provide the SDM an opportunity to participate fully in the plan of care. [s. 6. (5)]

3. The licensee has failed to ensure the resident was 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 changed or care set out in the plan was no longer necessary.

A) Record review revealed resident #026 was transferred to the hospital on an identified date in 2016, due to a change in health condition. The resident was diagnosed as having had an injury, which was treated and the resident returned to the home.
Observations of resident #026 on January 21, 22, 25 and 26, 2017, revealed they were wheelchair bound, had cognitive impairment, and relied on assistance of the staff for most of their activities of daily living.
Review of the resident's most recent written plan of care, indicated that the written plan of care was not revised with the current needs of the resident.
In an interview on January 30, 2017, registered staff #104 stated that the written plan of care was not revised when the resident's care needs changed and did not reflect the resident's current health condition. (591)

B) Resident #001 was observed on January 19, 2017, and had two bed rails on the bed that were applied while resident was not in bed. The resident was interviewed on January 26, 2017, and stated that they used both bed rails while in bed and that the bed rails were being applied at all times. PSW #120 was interviewed on January 26, 2017, and confirmed that the resident used both rails while in bed and both rails were being applied at all times. Furthermore, they stated that the resident received this new bed with bed rails attached on an identified date in 2016 and the staff were not informed of whether the bed rails should be up or down. Registered staff #123 confirmed that the resident used both bed rails and indicated that a list of residents that used Personal Assistance Services Device (PASDs) and bed rails was posted on the board at the nursing station, and confirmed that this resident was not on the list. The health care records were reviewed and the written plan of care did not include the use of bed rails for this resident. The SOC #101 and #100 confirmed that the resident was not re-assessed and the plan of care reviewed and revised when the resident received the new bed with bed rails. [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 the staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complement each other; to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care; to ensure 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

Resident #001 was observed on January 19, 2017 and had two bed rails on the bed that were applied while resident was not in bed. The resident was interviewed on January 26, 2017, and stated that they used both bed rails while in bed and that the bed rails were 'up' at all times. PSW #120 and registered staff #123 confirmed that the resident used both rails while in bed and both rails were being applied at all times and indicated the resident received the new bed with the rails on an identified date in 2016. The health care records were reviewed and the bed rail assessment could not be found when the resident received the new bed.
The "Bed Entrapment Prevention Program", revised, April 2013, indicated: "assess the resident for bed rail risk on admission and re-admission, with any significant change in condition, and following any incident related to safety in bed. See: Bed Rails Risk Assessment in the electronic health record".
The SOC #101 confirmed that the resident should have been re-assessed for safety in bed when they received the new bed in November 2016. [s. 15. (1) (a)]

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 bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee of a long term care home failed to protect residents from abuse by anyone.

Resident #028 had a history of inappropriate behaviours related to their health condition.

Recorded interviews revealed that on an identified date in 2016, there was an incident between resident #028 and co-residents #029, and #027. Resident #029 did not report this incident to staff until few days later. Interviews with registered staff #133 and dietary aide #134 indicated that this incident was not witnessed by staff; resident #027 also indicated that staff were not present at the time of the incident.

A review of resident #028's written plan of care, revealed that their behaviours were addressed in the plan of care. A review of the resident's health record did not indicate that resident #028 had previously been engaged in such incidents.

The Behavioural Support Ontario (BSO) registered staff #130 was interviewed and were aware of resident's behaviours.

Interview with SOC #115 confirmed that staff failed to protect resident #027, and resident #029 from the incident.

The licensee failed to ensure that residents were protected from abuse by anyone. (619) [s. 19. (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 residents are protected from abuse by anyone, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record review of resident #025's clinical health record revealed the resident fell on two identified dates in 2016. The Initial Post Fall assessments for the falls could not be located.
A review of the home's policy titled "Falls Prevention and Management Program", revised October 24, 2016, directed the nurse to follow the attached "Post Fall Guidelines", which indicated that an "Initial Post Fall Assessment" was to be completed within Risk Management and Point Click Care (PCC) after all falls.
In an interview on January 31, 2017, the Program Support Nurse/Educator, SOC #100 and SOC #114 confirmed Initial Post Fall assessments were not completed when resident #025 fell in 2016. [s. 49. (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 when the resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, 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 failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received 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.

A) On an identified date in 2015, resident #026 was visited by their SDM in the home. The SDM observed new alteration in skin integrity on resident's skin. Interview with PSW #128 indicated that they provided a shower to the resident and observed the resident's altered skin condition, and reported it verbally to registered staff #129. Interview with registered staff #129 indicated that the alteration in the skin integrity was not new. Interview with registered staff #119 indicated that when there is a change in the resident's skin condition, registered staff are required to initiate a weekly skin and wound assessment to track and monitor the skin changes until they are resolved. A review of the resident's health record did not indicate that a skin and wound assessment was completed for resident #026.

B) On an identified date in 2016, there was an incident between resident #029 and #029. A review of the resident's health record did not indicate that the resident's skin condition was assessed after the incident occurred.
Interview with registered staff #121 stated that resident #028 had an ongoing skin condition that was being assessed on a weekly basis, and indicated that this may have contributed to the reason why the resident's newly obtained skin alteration was not noted immediately by staff. A review of resident #029's progress notes indicated that the resident was seen by the home's Nurse Practitioner and a new skin alteration was described in progress notes.

A review of the home's policy titled, "Skin and Wound Care Program", last revised June 2016, stated, "The RN/RPN will, upon identification of altered skin integrity (pressure ulcer, skin tear, wound, burn, rash, abrasion, surgical wound, laceration, bruise etc.,) initiate a baseline assessment using the Skin and Wound Assessment on Point Click Care (PCC)".
Interview with SOC #115 confirmed that the registered staff failed to initiate and complete a skin assessment for resident's #026 and #029. [s. 50. (2) (b) (i)]

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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the physical device was applied in accordance with the manufacturer's instructions.

On January 24, 2017, LTCH Inspector observed resident #018 with a restraint that was not correctly applied. The registered staff #106 confirmed that the restraint was incorrectly applied. They also confirmed that the manufacturer's instructions for the application of the restraint were not kept at the nursing station. The registered staff #106 stated that the Activation and Volunteer Services Supervisor kept the manufacturer's instructions at their office. The Activation and Volunteer Services Supervisor was interviewed and confirmed that they did not have the manufacturer's instructions for the restraint.

Interviewed the PSW #116 who provided direct care to the resident and stated that they never received training on proper application of this type of restraint. They were not aware of how to apply it correctly and were not aware of the manufacturer's instructions on the application of the restraint. The Program Support Nurse confirmed that the education material did not include the demonstration or information related on proper application of the restraint.

The licensee failed to ensure that the restraint was applied in accordance with the manufacturer's instructions. [s. 110. (1) 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 physical device is applied in accordance with the manufacturer's instructions, to be implemented voluntarily.

WN #7: 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 was kept clean and sanitary.

Observation of three resident wheelchairs was completed by LTCH Inspector #561 on January 19, 2017 and by LTCH Inspector #640 on January 20 and 24, 2017.
Resident #013's wheelchair observed by the LTCH Inspector on three occasions, revealed a dirty cushion with dried fluid, debris on most of the frame and the top of the back rest, across the entire top portion of the backrest had a coating of white/grey stains. Resident #014's wheelchair observed by the LTCH Inspector on three occasions, revealed the cushion was dirty with crumbs and debris/dried spills. The frame was dirty with debris and dust. The leg/calf rest had debris/dried spills and the foot rest had debris and dried spills. Resident #004 wheelchair observation by LTCH Inspector on three occasions, revealed the frame to be dirty with debris and crumbs. There was what appeared to be dried jam on the frame under the left arm rest. The seat had dried fluid on the right cushion at the back of the cushion. The backrest had debris on the right side.

Interview with PSW #108 and PSW #109 told the LTCH Inspector the home expectation and policy is for all resident wheelchairs and other mobility equipment to be cleaned weekly prior to the first bath of the week. The cleaning was done on night shift and was scheduled as a task in Point of Care (POC).

The home's policy titled "Cleaning and Disinfection-Wheelchairs, Geri and Broda Chairs, Mobility Aids", policy #LTC9-07.19, revised September 1, 2011, directed staff to clean and disinfect all wheelchairs weekly on the night shift following a set procedure. Staff was directed to initial on the cleaning schedule once the wheelchair had been cleaned.
Review of POC documentation by the LTCH Inspector identified that the wheelchairs for residents #004, #013 and #014, had all been signed off as being cleaned by staff on the night of January 22, 2017.
Interview with SOC #101 regarding resident #004, confirmed the wheelchair was visibly dirty and was expected by the home to be cleaned weekly and spot cleaned as needed. The SOC confirmed the chair had not been cleaned or cleaned properly. Interview with SOC #114 regarding resident #013 and #014's wheelchairs confirmed that resident #013's wheelchair was unclean and required more cleaning to address the dirty cushion and dried fluid and debris on the chair and the frame. SOC #114 confirmed that resident #013's wheelchair was visibly soiled and did require cleaning and attention to detail. (640) [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure they respond in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

In an interview on January 24, 2017, the Residents' Council President confirmed that the licensee did not always respond in writing to related concerns or recommendations from the Council within ten days.

In an interview on the same day with the Activation and Volunteer Services Supervisor, who was the assistant to the Residents' Council confirmed the Council was not always provided a written response within ten days; however, a new form had been approved by management and the Residents' Council for use, which would begin immediately. A copy of the new form was provided to the LTCH Inspector. [s. 57. (2)]

WN #9: 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.

An observation by LTCH Inspector on January 23, 2017, of a medication cart on the fourth floor, revealed there were non-drug-related items in the cart which included loose change, five pairs of glasses and three empty glass cases.
In an interview, registered staff #113 confirmed the items were not drug-related; however, were kept in the medication cart for safe-keeping.
The licensee did not ensure the medication cart was used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

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.