Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 6, 2019	2019_565647_0024	019146-19	Critical Incident System

Licensee/Titulaire de permis

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

Smooth Rock Falls Hospital
107 Kelly Road P.O. Box 219 SMOOTH ROCK FALLS ON P0L 2B0

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

JENNIFER BROWN (647)

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): October 28, 29, 30, 2019.

The following intake was inspected upon during this Critical Incident System Inspection:
-one intake related to misappropriation of medication.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer (CEO), Long Term Care Manager, Registered Practical Nurses (RPN), Provincial Constable from the Ontario Provincial Police, and residents.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	Légende 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. 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 :

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #647 observed the medication management system together with Registered Practical Nurse (RPN) #102 on an identified date and time. The Inspector observed that in the bottom drawer of the medication cart was a small sharps container. RPN #102 indicated to the Inspector that the purpose of the sharps container was to dispose of any sharps during the administration of any injections and to dispose of any oral medications that residents may refuse.

During this same interview with RPN #102, they further indicated that any controlled substances that were refused at the time they were offered, would be disposed in the same sharps container that was located in the bottom drawer of the medication cart.

The Inspector asked the RPN if they were able to remove the sharps container from the medication cart. The RPN demonstrated to the Inspector, that they were able to easily lift it out of the medication cart as it was not stationary or locked within the medication cart.

During an interview with the Long Term Care Manager, they acknowledged that the practice of the home was to dispose of any used sharps, or refused medications that included controlled substances into the sharps container, that was located in the bottom of the medication cart. The Long Term Care Manager further indicated that the sharps container was not secured to the medication cart or stationary, and that it would be able to be easily removed from the cart. [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 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 #2: 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 :

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

A Critical Incident System (CIS) report was submitted to the Director for improper/incompetent treatment of a resident that affected residents #001, #002, #003, #004, and #005.

A review of a report indicated, that medications were discovered not to be administered.

Inspector #647 completed a record review of the current physician's orders. The record review indicated that all of these residents had current physician orders to receive these medications, and should have received them as prescribed.

Inspector #647 reviewed the medication administration record (MAR) for these residents, for the corresponding dates of the located medications. The review identified that RPN #104 had documented that they had administered the medication to these residents.

During an interview with the Long Term Care Manager, they confirmed to the Inspector, that the above medications had not been administered to resident's #001, #002, #003, #004, and #005, 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.

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.