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
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 8, 2014	2014_362138_0001	O-000177-14	Resident Quality Inspection

Licensee/Titulaire de permis

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

TOWNSHIP OF OSGOODE CARE CENTRE
7650 SNAKE ISLAND ROAD, METCALFE, ON, K0A-2P0

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

PAULA MACDONALD (138), JOANNE HENRIE (550), LISA KLUKE (547)

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): March 26, 27, 28, 31, April 1, 2, and 3, 2014

The RQI also included Complaint Inspection O-000087-14

During the course of the inspection, the inspector(s) spoke with several residents and family members, a lead for the Residents' Council, a member of the Family Council, the Administrator, the Nutrition Manager, the Registered Dietitian, the Director of Care (DOC), the Associate Director of Care (ADOC), the RAI Coordinator, the Recreation Director, several registered nurses (RN), several registered practical nurses (RPN), several personal supports workers (PSW), several food service workers (FSW), and Maintenance.

During the course of the inspection, the inspector(s) reviewed several residents' health care records, reviewed several of the home's policy and procedures, reviewed the document from Health Canada, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" effective 2008/03/17 toured resident rooms, toured resident common and non common areas, reviewed Residents' Council minutes, observed a medication pass, observed a lunch meal service and a breakfast meal service, and observed the delivery of resident care and services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (6) For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable. O. Reg. 79/10, s. 136 (6).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10 s. 136. (6) in that the licensee has not ensured that when a drug is destroyed, the drug is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

On April 1, 2014 at 8:55am, Long Term Care Homes (LTCH) Inspector #547

interviewed the DOC to review drug destruction locations and procedures. The DOC stated that drug destruction boxes are fixed to the medication carts for registered staff use and that registered staff indicate destroyed drugs in the electronic medication administration record (e-MAR) system.

On April 1, 2014 at 9:03am, LTCH Inspector #547 interviewed Staff #101 who indicated that non-controlled drugs are destroyed on the medication carts in the boxes on the side of the carts. Staff #101 further stated that there are larger drug destruction boxes in the locked medication rooms for drugs that are discontinued or expired.

On April 1, 2014 at 11:42am, LTCH Inspector #547 observed Staff #112 dispose of expired drugs in the large drug destruction box in the medication room for Maple Lane/ Walnut Trail. It was noted that the drugs disposed of were not altered or denatured to such an extent that their consumption was rendered impossible or improbable.

On April 2, 2014 at 2:34pm, LTCH Inspector #547 interviewed Staff #113 concerning the drug destruction procedure. Staff #113 stated that registered nursing staff dispose of non-controlled drugs by placing the drug in the drug destruction boxes in the locked medication room but that no additional steps were taken, such as adding a fluid, to destroy the drugs.

On April 3, 2014 at 10:17am, LTCH Inspector #547 interviewed Staff #106 concerning the drug destruction procedure. Staff #106 stated that registered nursing staff for the home are to dispose and destroy non-controlled drugs in the drug destruction box in the medication rooms for the unit and complete the Drug Destruction Form Record for the drug that is destroyed. The Drug Destruction Form Record is kept next to the drug destruction box.

On April 3, 2014 at 8:14am, LTCH Inspector #547 interviewed the ADOC and DOC concerning the drug destruction policy for the home. The home's drug destruction policy is from the Policy and Procedure Manual - Multi-Dose System provided by Classic Care Pharmacy, reviewed February 2014. Section 5 of this manual has the policy known as 5.8 Clinical Pharmacy Services- Medication Disposal. This policy indicates the following:

Policy for Medication Destruction: LTCH's
(bullet 2) With the exception of controlled substances, medications designated for

disposal are destroyed at the home by a team of individuals comprised of a registered nursing staff member and another staff member, both of whom are appointed by the Director of Care.

Procedure:
(#3) The medications are denatured to an extent that consumption is impossible or improbable and the designated drug destruction container is sealed. In most cases, liquid (water or discontinued liquid medication) is poured over the disposed medications.

(#4) The nursing personnel who performed the destruction each sign and date a Medication Destruction Record Form.

LTCH Inspector #547 reviewed the home's Policy and Procedure section 5.8 provided by Classic Care Pharmacy with the ADCO and the DOC. The ADOC and DOC both stated that they did not realize that the home was required to denature non-controlled drugs as part of drug destruction and that registered nursing staff were not informed to denature non-controlled drugs in the home.

As such, the licensee has not ensured that when a drug is destroyed, the drug is altered or denatured to such an extent that it's consumption is rendered impossible or improbable. [s. 136. (6)]

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 a drug is destroyed, the drug is altered or denatured as indicated by the home's policy and procedure, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10 s. 229. (10) 1. in that each resident admitted to the home is not screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Resident #451 was admitted in November 2011. The first step tuberculosis (TB) testing, as per the home's policy for TB screening at the time, was not preformed until sixty-six days after admission. The second step TB testing for Resident #451 was completed fourteen days after that.

Resident #476 was admitted to the home in December 2011. The first step TB testing was not preformed until thirty-six days after admission. A chest X-Ray was done following a positive result from the TB testing.

During a discussion on April 1, 2014 at 1:00pm, the DOC stated to LTCH Inspector #550 that it is the expectation in the home that TB testing is done to all residents within 14 days of admission. She confirmed Resident #451 and Resident #476 did not receive TB testing within 14 days of admission. [s. 229. (10) 1.]

2. The licensee failed to comply with O. Reg 79/10, s. 229. (10) 3. in that residents are not offered immunizations against pneumoccocus, tetanus, and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.

Immunization record for Resident #406 was reviewed in both Point Click Care (PCC) and the hard copy of the resident's chart. Written consent was obtained for diphtheria/tetanus vaccination for the resident but there was no documentation that the vaccine had been offered.

Immunization record for Resident #451 was reviewed in both PCC and the hard copy of the resident's chart. Written consent was obtained for diphtheria/tetanus vaccination for the resident but there was no documentation that the vaccine had ever been offered.

LTCH Inspector #550 observed that the diphtheria/tetanus vaccine was not available in the vaccine storage refrigerator located in the medication storage room next to the beauty salon.

LTCH Inspector #550 spoke with Staff #101 regarding vaccinations for residents and Staff #101 stated that the diphtheria/tetanus vaccination are not offered to residents.

LTCH Inspector #550 spoke with the DOC regarding the vaccination of residents for diphtheria/tetanus and the DOC stated that the home has only recently begun to implement the diphtheria/tetanus immunization program. The DOC further stated that most residents in the home did not receive the diphtheria/tetanus vaccine even if the resident/substitute decision maker had signed consent for administration of the diphtheria/tetanus vaccination. [s. 229. (10) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident admitted to the home is screened for tuberculosis within 14 days of admission and residents are offered immunizations against tetanus and diphtheria, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (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).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA, 2007 S.O. 2007, c.8, s.6. (1) (c) in that the plan of care does not set out clear directions to staff and others who provide direct care to the resident.

Upon entry to the home on March 26, 2014, the Administrator stated to LTCH Inspector #138 that the plan of care for residents includes all documentation related to the resident (assessment, care plans, progress notes, etc).

On April 1, 2014 at 10:00am, LTCH Inspector #550 reviewed Resident #482's plan of care including the health care record, the recent PCC care plan, and the cardex. It was noted by LTCH Inspector #550 that the PCC care plan had indicated that Resident #482 had a foley catheter in place.

Later that morning at 10:30am, LTCH Inspector #550 spoke with Staff #101 who stated that Resident #482 no longer had a foley catheter and that it had been recently removed. LTCH Inspector #550 reviewed the plan of care including the progress notes, the PCC care plan, and the cardex. The LTCH Inspector noted that there was an entry in the progress notes stating that the foley catheter had been removed but that the PCC care plan still indicated that the resident had a foley catheter. The DOC had stated to LTCH Inspector #138 that the registered nursing staff use the PCC care plan to guide the staff on residents' care needs. LTCH Inspector #550 reviewed the cardex dated February 10, 2014 for the resident. Staff #110 stated to LTCH Inspector #138 that the cardex was used by care staff to guide them in delivering care to the residents. It was noted by LTCH Inspector #550 that the cardex had not been updated with changes related to the use of the foley catheter for Resident #482.

The resident's plan of care did not contain any additional information to guide care staff in delivering continence care to Resident #482 after the removal of the foley catheter. [s. 6. (1) (c)]

2. The licensee failed to comply with LTCHA 2007 S.O. 2007, c.8, s. 6. (8) in that staff and others who provide direct care to a resident are not kept aware of the contents of the plan of care nor have convenient and immediate access to it.

On April 1, 2014, Staff #101 told LTCH Inspector #550 that registered staff use the electronic copies of the residents' care plan in PCC and that printed copies are no longer routinely made available. Staff #101 told LTCH Inspector #550 that the PSW's do not have access to PCC and they do not have access to the PCC care plans. The DOC stated to LTCH Inspector #138 that the PSW's have a printed cardex for each resident that is meant to guide them in delivering care to residents. The DOC further stated that there is a printed copy of each resident cardex that is kept in a binder with the flow sheets at the nursing station. LTCH Inspector #550 reviewed the cardex for Resident #482 and noted that there was no provision of continence care documented for Resident #482 especially with the presence of complicating health conditions. [s. 6. (8)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s. 9. (1) 2. in that the licensee failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

LTCH Inspector #550 observed on the initial tour of the home on March 26, 2014 that a door to the soiled utility/soiled linen room on the West hallway was closed but not locked. The same inspector noted that there was nothing of immediate risk to residents in the soiled utility/soiled linen room. Two days later on March 28, 2014, LTCH Inspector #138 observed prior to lunch on the West hallway that the door to the soiled utility/soiled linen was closed but again not locked. LTCH Inspector #138 also noted on the West hallway that the door to the storage room (located next to the tubroom) was closed but not locked and on the South hallway that the door to the soiled utility room was also closed but not locked. Again, nothing of immediate risk to residents was observed in these rooms.

On March 31, 2014 LTCH Inspector #138 followed up on the previously identified doors in the West and South hallways that were identified as unlocked. At approximately 9:45am, LTCH Inspector #138 observed on the West hallway that there were no visible staff and that there were two residents walking in the hallway. It was observed that the door to the soiled linen/soiled utility room was closed but not locked. It was also observed that the door to the storage room (next to the tubroom) was open and unsupervised. After closing the door to the storage room, LTCH Inspector #138 proceeded to the South hallway at approximately 9:50am and observed that the door to the linen room and the door to the soiled utility room were both closed but not locked.

LTCH Inspector #138 then spoke with Staff #103 regarding the doors to both the soiled linen/soiled utility room and the storage room (by the tubroom) on the West hallway. Staff #103 reported working in the home for several years and stated that these doors have always been unlocked. LTCH Inspector #138 also spoke with Staff #104 regarding the doors to both the linen room and the soiled utility room on the South hallway. Staff #104 also stated that these doors have always been unlocked and further told the inspector about a resident who will enter the linen room unsupervised to go through the items of lost laundry.

LTCH Inspector #138 observed that the soiled linen/soiled utility room and the storage room (next to the tubroom) on the West and the soiled linen room and the utility room on the South hallway did not have a resident-staff communication and response system (ie call bell system) that would be required in accordance with O. Reg 79/10 s. 17. (1) (e) if these rooms were to be accessible by residents.

LTCH Inspector #138 spoke with the home's Administrator later that same day at approximately 1:15pm regarding the observed doors that were not locked. The Administrator stated that she was of the belief that these doors were locked. LTCH Inspector #138 and the Administrator proceeded to the West hallway and observed that the door to the soiled linen/soiled utility room and the door to the storage room (next to the tubroom) were closed but not locked and, on the South hallway, that the door to the linen room and the door to the soiled utility room were closed but not locked. The Administrator stated that these rooms were not meant to be accessible to residents. She further stated that she would have locks installed on the doors as soon as possible. It was noted by LTCH Inspector #138 on April 2, 2014 that the doors were equipped with a keypad style lock and all doors were closed and locked. [s. 9. (1) 2.]

WN #5: 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 failed to comply with O. Reg 79/10, s. 15. (1) (b) in that steps taken to prevent resident entrapment did not take into consideration all potential zones for entrapment.

Resident #464 was a randomly selected resident for Stage 1 activities of the Resident Quality Inspection (RQI). On March 27, 2014, LTCH Inspector #138 completed an observation of Resident #464's room. LTCH Inspector #138 observed that the resident's bed had two quarter rails in the up position. Upon further inspection, it was noted that the resident had a raised perimeter mattress that did not fully fit the deck of

the bed. This created a gap between the left side of the mattress and the inside of the left rail that was large enough for the inspector to place a fist into the gap. It was also observed by LTCH Inspector #138 that the left rail was not stable and shifted laterally several centimeters which may have contributed to the width of the gap. LTCH Inspector #138 reported the concerns with the resident's rail to the DOC. Both LTCH Inspector #138 and the DOC proceeded to view the resident's bed. The DOC stated that she agreed with the concerns related to the rail that was demonstrated by the LTCH Inspector and stated that she would have the rail repaired immediately. In addition, the DOC stated that she would order padding for the rail that would further reduce the gap. LTCH Inspector #138 followed up with the rail on March 28, 2014 and noted that the left rail had been fixed and that it was stable. It was observed by the inspector that there was still a gap between the side of the mattress and the inside of the left rail although the gap had lessened with the repair of the rail. The additional padding for the rail had not been installed but the DOC stated that it had been ordered. LTCH Inspector #138 flagged the concern for in-depth followed up in Stage 2 of the RQI. It was noted by the LTCH Inspector that Resident #464 had safety measures in place including that would notify staff of significant resident movement while in bed.

On March 31, 2014, LTCH Inspector #138 reviewed the document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", Health Canada, effective 2008/03/17. This document indicates that the space between the inside of the mattress and the inside of the rail (referred to as zone 3) should be small enough to prevent head entrapment when taking into account the mattress compressibility, lateral shift of the mattress, or lateral shift of the rail. Further, this document recommends a dimensional limit for zone 3 of 120mm as 120mm represents the dimension of the narrowest part of a person's head.

After reviewing the document, LTCH Inspector #138 proceeded to Resident #454's bed. The inspector noted that the padding on the rail had not yet been installed. The inspector noted that the mattress easily moved around on the bed deck when bumped with the inspector's thigh. Once the inspector shifted the mattress to the right it was noted that the gap between the side of the mattress and the inside of the left rail increased further. A measurement was taken by LTCH Inspector #138 from the inside of the mattress to the inside of the left rail near head of the bed. The measurement was recorded at 130mm. LTCH Inspector #547 also verified the measurement. It was noted that the measurement, without taking into consideration the compression of the foam mattress, was more that the recommended limit of 120mm as indicated by

Health Canada. It was noted by LTCH Inspector #138 that the compression of the mattress increased the measurement of the gap beyond the 130mm previously taken.

LTCH Inspector #138 then spoke with the DOC and the Administrator regarding Resident #464's bed. The DOC voiced concerns over the resident's bed and stated that the padding for the rail would not be in until the following day. Both the DOC and Administrator suggested swapping the mattress on Resident #464's bed. The mattress was swapped immediately and it was observed by LTCH Inspector #138 that the gap between the inside of the mattress and side rail on both sides was appropriate. The DOC stated that the removal of the raised perimeter mattress, which was used as a falls prevention measure, was unlikely to impact the resident as there were many other interventions in place to manage the resident's falls. [s. 15. (1) (b)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg 79/10, s. 114. (3) (a) in that the licensee has not ensured that written policies and protocols related to medication management systems are implemented.

On April 1, 2014 at 11:02am, LTCH Inspector #547 observed during the inspection of the narcotic box for Maple Lane and Walnut Trail that two residents were not provided their narcotics as indicated on the eMAR.

Specifically, Resident #456 did not receive Clonazepam at 8:00am as indicated by the eMAR but received the medication later that morning after 11:00am. LTCH Inspector #547 observed that a note indicating that the resident's medication was withheld due

to drowsiness of the resident was placed on Staff #106's information gathering sheet for shift report. Conversly, it was noted by the inspector that the eMAR did not indicate that the medication had been withheld but had identified that the medication was provided as directed at 8:00am. LTCH Inspector #547 reviewed the progress notes for Resident #456 and noted that there was an entry completed indicating that Clonazepam was given to the resident at the time of the progress note entry which was more than three hours than documented in the eMAR. On April 2, 2014 at 12:30pm, LTCH Inspector #547 reviewed the Maple Lane Resident's Individual Narcotic and Controlled Drug Count Sheet and noted that the sheet indicated that on April 1, 2014 Resident #456 received the 8:00am scheduled administration of Clonazepam at 11:00am.

Also, Resident #002 did not receive hydromorphone at 8:00am due to drowsiness. The eMAR indicated that this medication had been given as ordered at 8:00am. LTCH Inspector #547 observed that a note indicating that the resident's medication was withheld due to drowsiness of the resident was placed on Staff #106's information gathering sheet for shift report. Conversly, it was noted by the inspector that the eMAR did not indicate that the medication had been withheld and instead had identified that the medication was provided as directed at 8:00am. LTCH Inspector #547 reviewed the progress notes for Resident #002 and noted that there was an entry completed indicating that hydromorphone was given to the resident. LTCH Inspector #547 observed Staff #106 administer hydromorphone to Resident #002 at approximately 11:00am, three hours later than indicated in the eMAR. On April 2, 2014 at 12:30pm, LTCH Inspector #547 reviewed the Maple Lane Resident's Individual Narcotic and Controlled Drug Count Sheet and noted that the sheet indicated that on April 1, 2014 Resident #002 received the 8:00am scheduled administration of hydromorphone at 11:00am.

On April 02, 2014 at 12:23pm, LTCH Inspector #547 spoke with Staff #114 regarding the documentation practice when registered nursing staff decide to withhold a resident's medication. Staff #114 stated that when registered nursing staff decide to withhold a medication the staff will indicate this decision in e-MAR which will then require the staff to make an entry in the resident's progress notes about the reason the medication was withheld. Staff #114 was able to demonstrate this practice to the LTCH Inspector.

On April 2, 2014 at 1:26pm, LTCH Inspector #547 reviewed the home's Policy and Procedure Manual- Multi-Dose system provided by Classic Care Pharmacy last

reviewed February 2014. Section 4 of this manual has the following policies regarding administration of medication:

#4.2 Administration, Documentation and Storage regarding Administering Routine Medications, Procedure #3. Each individual medication is initialed as administered, on the MAR, in the correct boxes, immediately after administration and before the next resident is medicated.

#4.3 Administration, Documentation and Storage regarding Administering and Documenting Narcotic Medications. The narcotic medication is initialed as administered, on the MAR, in the correct box, immediately after administration and before the next resident is medicated.

#4.5 Administration, Documentation, and Storage regarding non-administered Medications indicates. In the event that a scheduled medication pass/dose cannot be made, documentation of the non-administered medication must ensue.
#1.The numbered legend may be used in the MAR sheet to document any scheduled does that are not administered to the resident.
#2. The "poured" medications are removed from the dispensing area of the medication cart/cup and placed in the container designated for discarded medications. Alternatively, the wasted medications are immediately disposed of in a safe manner, according to section.

On April 2, 2014 at 12:36pm, LTCH Inspector # 547 spoke with the DOC regarding the documentation of withheld medications for Resident #456 and Resident #002 that occurred on April 1, 2014. The DOC stated that staff are to document in the eMAR any medications that are withheld and then ensure that a progress note has been completed to outline the reasons why the medication has been withheld. The DOC further stated that pre-signing of any medication is not in accordance with the home's policy for medication administration. [s. 114. (3) (a)]

WN #7: 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 comply with O. Reg 79/10, s. 129. (1) (a) (iv) in that the licensee did not ensure that drugs are stored in an area or a medication cart that complies with manufacturer's instructions for the storage of the drugs regarding expiration dates.

On April 1, 2014 at 11:42am, the medication cart for Maple Lane/Walnut Trail was observed to contain expired medication:

Resident #473 had an order for Loperamide Hcl that had expired in April 2013. It was noted that the medication was present on the medication cart with several tablets gone from the folder. LTCH Inspector #547 reviewed the MAR since April 2013 and noted that the resident did not consume the medication since the order expired.

Resident #402 had an order for Olanzapine. This ordered had expired in July 2013 and it was noted by LTCH Inspector #547 that no tablets were used from this medication blister pack on the medication cart.

Resident #001 has a current order for Lactulose. There were two bottles of Lactulose for this resident located in the bottom of the medication cart. It was noted by LTCH Inspector #547 that one of the bottles of Lactulose had an expiration of December 2013.

LTCH Inspector #547 reviewed the home's Policy and Procedure Manual- Multi-Dose system provided by Classic Care Pharmacy (February 2014). Section 5 of this manual

contains the policy, 5.8 Policy for Medication Destruction: LTCH's. This policy states the following:
Classic Care Pharmacy encourages that the home routinely inspects all medication storage areas, perhaps monthly, for the ongoing identification, destruction and disposal of expired drugs, drugs with illegible labels, and drugs in containers without legislated prescription labeling.

On April 3, 2014 at 8:32pm, LTCH Inspector #547 spoke with the DOC regarding the home's policy for identification, destruction and disposal of expired drugs. The DOC stated that she previously directed the night RN to check the Government Stock located in the Nursing Supply room near the Villages Health Centre nursing station.

LTCH Inspector #547 obtained a copy of the night RN's routine for the Villages Health Centre. The routine states the following:
"Stock supplies in med room from supply cupboard. Check monthly for expired medications."

The DOC stated that the night RN's were only directed to verify Government Stock in the Nursing Supply for expiry dates and further stated that specific direction was never given to verify the medication rooms or medication carts for every nursing unit. [s. 129. (1) (a)]

Issued on this 8th day of April, 2014

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