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 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 15, 2018	2018_543561_0014	016531-18, 018039-18, 018618-18	Complaint

Licensee/Titulaire de permis

The Regional Municipality of Halton
1151 Bronte Road OAKVILLE ON L6M 3L1

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

Allendale
185 Ontario Street South MILTON ON L9T 2M4

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

DARIA TRZOS (561)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): August 29, 30, 31, 2018 and September 4, 2018

A Critical Incident System (CIS) Inspection number M536-0000-22-18, log number 022668-18 related to unaccounted for/missing narcotics, was completed concurrently during this inspection. Non compliance related to s. 8 (1) (b) was identified and issued as a Compliance Order (CO) in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, Senior Nursing Manager, Housekeeping/Laundry Supervisor, Registered staff including Registered Nurses (RNs) and Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), resident and family.

During the course of the inspection, the inspector observed the provision of care, reviewed clinical records, investigation notes, training records and policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Medication
Personal Support Services
Reporting and Complaints
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **1 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. 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg 79/10 s. 114 (2), the license was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A) The home's policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-03-20, indicated that narcotics and controlled substances that are awaiting destruction were to be stored in a separate double locked stationary cupboard in a locked medication room.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home's investigation notes were reviewed by LTCH Inspector #561, and indicated that during an identified shift on an identified date, registered staff noted a discrepancy in the narcotic count. In an interview with the home, registered staff #103 who worked on that shift, removed incorrect doses of a narcotic prescribed to resident #001. There were two cards of the identified narcotic that were discontinued and two cards with the narcotic for regular administration. When the registered staff noticed the discrepancy they left the pills from the discontinued card in a medication cup in the top drawer of the medication cart. Then, they administered the correct dose to the resident from the narcotics that were prescribed for regular administration. The investigation notes stated that the registered staff indicated they had intentions to waste the medication that they removed

from the discontinued card at shift change but forgot.

The clinical record review and the investigation notes indicated that the discontinued narcotics, were stored with the regular scheduled narcotics for administration in the narcotic bin of the medication cart for several days prior to the incident.

During the inspection, LTCH Inspector #561 interviewed registered staff #103. They stated that they removed the discontinued narcotics by mistake and noticed that there were two other cards with narcotics for regular administration. They placed the discontinued tablets in the top drawer of the medication cart in a medication cup and then they administered the regular dose from the card that was scheduled to be administered. The registered staff stated that they had intended to waste the discontinued narcotics with another registered staff but forgot to do it.

In an interview, the Senior Nursing Manager also acknowledged that the staff failed to comply with the home’s policy related to the storage of narcotic and controlled substances awaiting destruction. The Senior Nursing Manager indicated that the narcotics from the discontinued cards should have been wasted right away instead of being left in the top drawer of the medication cart.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18.

B) The home’s policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-03-20, indicated that all monitored drugs must be counted (jointly) at every shift change by two registered staff, one coming on shift and one going off shift, both will verify by signature the quantity of each monitored medication on hand with the Narcotic and Controlled Substance Administration Record (NSCAR).

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home’s investigation notes were reviewed by LTCH Inspector #561, and indicated that on an identified date registered staff #103 failed to count the narcotics with the nurse at shift change and failed to count the narcotics with another nurse when they were leaving.

Registered staff #103 was interviewed by LTCH Inspector #561 and stated that they did

not do the shift count of narcotics with the registered staff on the unit as that registered staff was behind and busy on the unit. They also stated that they did not count the narcotics at the end of their shift with another registered staff.

The Senior Nursing Manager was interviewed and acknowledged that the registered staff failed to complete narcotic counts on several shifts at shift change.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18.

C) The home's policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-03-20, indicated that the RN/RPN must count the monitored medication immediately upon opening the tamper proof bag and confirm quantity, documents the date, time and total quantity received from pharmacy and signs the top right hand corner of the Narcotic and Controlled Substance Administration Record (NCSAR). A second registered staff member witnesses and co-signs the NSCAR ensuring the count is correct and signing in both the top right corner and the "checked by" section of the NSCAR.

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing/unaccounted for in the home.
The home's investigation notes were reviewed by LTCH Inspector #561, and identified that on an identified shift, registered staff #109 received medications from the pharmacy including narcotics for resident #006. Narcotics for this resident included 20 individual medications for regular schedule and 20 for as needed (PRN) administration. There were four boxes together and a rubber band separated the regular from PRN medications providing two boxes of PRN medication.

The home's investigation notes indicated that when the registered staff received the medications they opened the sealed foil that contained the boxes and signed the narcotic sheet (NSCAR). The registered staff failed to open each individual box to count each medication. They assumed that all 10 medications were inside each box. Then, the registered staff gave the narcotics to another registered staff #110, on the unit where resident #006 resided. Registered staff #110 took the boxes, did not open them individually and signed the NSCAR indicating that all 10 ampules were present in each box. The registered staff did not do the count together.

The clinical record review indicated that the registered staff on the oncoming shift, counted the narcotics with registered staff #110 and found that one of the boxes of PRN

narcotics had only eight medications in it. Two were missing. The packaging slip from the pharmacy indicated that there were 20 medications in total delivered to the home. The registered staff immediately reported this to the Manager on call.

Registered staff #109 was interviewed by LTCH Inspector #561 and stated that once they received the narcotics they failed to count them together with another registered staff and that they did not open each individual box that contained the medications. They assumed that there were 10 medications in each box as indicated on the box.

Registered staff #110 was interviewed by LTCH Inspector #561 and stated that they failed to open each individual box to count how many medications were inside each box. They signed the NSCAR assuming all 20 medications were inside in the boxes marked PRN.

Both registered staff members acknowledged that they failed to follow the home's policy and the best practice guidelines regarding handling of controlled substances.

In an interview, the Senior Nursing Manager acknowledged that the registered staff failed to follow the policy and failed to count the narcotics together and failed to open each individual box to count what was inside. The narcotics were not found and remain unaccounted for.

The licensee failed to ensure that their policy related to Narcotics/Controlled/Monitored Drugs was complied with.

This area of non-compliance was identified during a CIS Inspection, log #022668-18.

D) The home's policy titled "Return from Hospital (Readmission)", procedure #06-01-07, revised October 28, 2014, stated that upon re-admission registered staff were to review any documentation, process the hospital physician's orders as listed on the transfer sheet, confirm orders with physician and fax the form to the pharmacy. The re-admission order form indicated that two registered staff signatures were required upon reconciliation of medications.

The Ministry of Health and Long Term Care, received a complaint log number 018039-18 on an identified date in 2018, related to medication administration.

The clinical records review indicated that on an identified date in 2018, resident #001

was readmitted to the home from the hospital with medication changes. The re-admission form was reviewed and indicated that one of the medications was ordered as needed (PRN). The re-admission orders were confirmed by the physician when the resident returned. The Electronic Medication Administration Record (EMAR) was reviewed, and indicated that the re-admission order was added to the EMAR when resident returned as a regular scheduled medication and not PRN.
The home completed an investigation into the error and completed the medication incident report. The home's investigation notes stated that the registered staff did not complete a second check after re-admission and the error was not identified until several days later. The medication incident report stated that the registered staff entered the order on Point Click Care (PCC) as every four hours. The pharmacy did not send this order and had PRN order on their records. Resident received the medication as regular scheduled instead of PRN for several days.
The re-admission order form indicated that the second check of medication reconciliation was not completed by registered staff until several days after return.

Registered staff #102 was interviewed by LTCH Inspector #561 and stated that resident #001 received the medication as regular scheduled instead of PRN for several days.

In an interview, the Senior Nursing Manager acknowledged that resident received the wrong dose of the medication for several days until the error was identified. The Senior Nursing Manager stated that the home's process was to complete the re-admission order form to reconcile medications, confirm orders with the physician and a second check was required by registered staff when reviewing the medications orders. The Senior Nursing Manager acknowledged that the second check was not completed by registered staff upon re-admission.

This area of non-compliance was identified during a Complaint Inspection, log #s 016531 -18, 018039-18, and 018618-18.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The Ministry of Health and Long Term Care, received a complaint on an identified date in 2018, related to improper management of a resident's condition. As per the complainant resident was admitted to the hospital on an identified date 2018 with a change in symptoms.

The plan of care for resident #001 was reviewed by LTCH Inspector #561, and identified that resident had an identified health condition. The written plan of care indicated that resident was to be monitored for signs and symptoms of the condition and to check resident signs and symptoms every week on an identified day. The progress note made by the Registered Dietitian (RD), indicated they were unsure of the management of the resident's condition and to consider getting an order for the specified monitoring.
The quarterly review by the Pharmacy on an identified date stated to order the monitoring weekly.

Registered staff #107 was interviewed and acknowledged that the written plan of care stated to complete monitoring of the symptoms ever week on an identified day; however, following the review of the medical record, they did not see this as being done.
Registered staff #107 checked the lab binder and clinical care records and stated that the identified monitoring was not being done.

The Senior Nursing Manager was interviewed and acknowledged that there was no follow up completed after the quarterly review completed by the Pharmacy and after RD’s assessment.

The Senior Nursing Manager acknowledged that the staff should have obtained an order from the physician for the monitoring of the specified condition. The Senior Nursing Manager stated that they had registered staff obtain an order from the physician during this inspection.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in the plan.

This area of non-compliance was identified during a Complaint Inspection, log #s, 016531-18, and 018039-18. [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee 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.

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home’s investigation notes were reviewed by LTCH Inspector #561, and indicated that during an identified shift on an identified date, registered staff noted a discrepancy in the narcotic count. In an interview with the home, registered staff #103 who worked on that shift, removed incorrect doses of a narcotic prescribed to resident #001. There were two cards of the identified narcotic that were discontinued and two cards with the narcotic for regular administration. When the registered staff noticed the discrepancy they left the pills from the discontinued card in a medication cup in the top drawer of the medication cart. Then, they administered the correct dose to the resident from the narcotics that were prescribed for regular administration. The investigation notes stated that the registered staff indicated they had intentions to waste the medication that they removed from the discontinued card at shift change but forgot. The medication that was left in the top drawer of the medication cart went missing and where not found by the home.

During the inspection, LTCH Inspector #561 interviewed registered staff #103. The registered staff stated that they removed the discontinued narcotics by mistake and noticed that there were two other cards with narcotics for regular administration. They placed the discontinued tablets in the top drawer of the medication cart in a medication cup and then they administered the regular dose from the card that was scheduled to be administered. The registered staff stated that they had intended to waste the discontinued narcotics with another registered staff but forgot to do it.

The Senior Nursing Manager acknowledged that registered staff #103 should not have left the narcotics in the top drawer of the medication cart.

The licensee failed to ensure that the narcotics were stored in a separate double locked area in the locked medication cart.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18. [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 #4: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ministry of Health and Long Term Care, received a complaint on an identified date in 2018, related to medication administration.
The clinical records review indicated that on an identified date in 2018, resident #001 was readmitted to the home from the hospital with medication changes. The re-admission form was reviewed and indicated that one of the medications was ordered as follows as needed (PRN). The re-admission orders were confirmed by the physician when resident returned. The Electronic Medication Administration Record (EMAR) was reviewed and identified that a specified medication that was ordered as PRN was added to the EMAR as regular scheduled medication.

The home completed an investigation into the error and completed the medication incident report. The home's investigation notes stated that the registered staff did not complete a second check after re-admission and the error was not identified until several days later.

Registered staff #102 was interviewed by LTCH Inspector #561 and stated that resident #001 received a specified medication regularly scheduled instead of PRN for several days. The registered staff indicated that it was a pharmacy error as they had entered it into EMAR as a regular dose.

In an interview, the Senior Nursing Manager acknowledged that resident received the wrong dose of the medication for several days until the error was identified.

The licensee failed to ensure that drugs were administered to resident #001 in accordance with the directions for use specified by the prescriber.

This area of non-compliance was identified during a Complaint Inspection, log #s 016531-18, 018039-18, and 018618-18. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

A) The Ministry of Health and Long Term Care received a complaint on an identified date related to resident #001's sleep patterns and routines. The complainant indicated that PSW staff in the home were asking the resident if they wanted to go to bed before supper time.

Resident #001 was interviewed during this inspection and stated that sometimes staff asked them if they wished to go to bed prior to the activities after supper. The resident indicated that they participate in the evening activities and did not wish to go to bed that early. The resident also stated that the home did not ask them upon admission or since admission what their sleeping routines and preferences were.

The review of the plan of care for resident #001 indicated that the plan of care was not based on their sleep patterns and preferences. The written plan of care did not indicate what the resident’ s routines and patterns were, for getting up in the morning and for bedtime.

B) Resident #003’s written plan of care was reviewed by LTCH Inspector #561, and did not include resident’s sleep patterns and preference. The PSW #108 was interviewed and stated that resident preferred to go to bed after supper.

In an interview, the Senior Nursing Manager stated that they were aware of the legislative requirement and acknowledged that the plan of care should include residents’ sleep patterns and preferences.

The licensee failed to ensure that the plan of care for residents #001 and #003 was based on the assessment of their sleep patterns and preferences.

This area of non-compliance was identified during a Complaint Inspection, log #s 016531 -18, 018039-18. [s. 26. (3) 21.]

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home’s investigation notes were reviewed by LTCH Inspector #561.
The incident was immediately reported to the Manager of Resident Care; however, the CI report was not submitted to the Director within one business day.

In an interview, the Senior Nursing Manager acknowledged that the missing narcotics were not reported to the Director within one business day.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18. [s. 107. (3) 3.]

Issued on this 26th day of November, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DARIA TRZOS (561)
Inspection No. / No de l'inspection :	2018_543561_0014
Log No. / No de registre :	016531-18, 018039-18, 018618-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 15, 2018
Licensee / Titulaire de permis :	The Regional Municipality of Halton 1151 Bronte Road, OAKVILLE, ON, L6M-3L1
LTC Home / Foyer de SLD :	Allendale 185 Ontario Street South, MILTON, ON, L9T-2M4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sean Weylie

To The Regional Municipality of Halton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the LTCHA, 2007.

Specifically, the licensee must:
1. Ensure that the written polices and protocols related to Narcotics/Controlled/Monitored Drugs are complied with.
2. Ensure that two registered staff at shift change count the narcotics together and sign the Narcotic and Controlled Substance Administration Record together.
3. Ensure that when narcotics are delivered to the home, two registered staff count all individual narcotics together and sign the Narcotic and Controlled Substance Administration Record together to account for the received narcotics.
4. Ensure that registered staff comply with the re-admission policy related to reconciliation of medications.

Grounds / Motifs :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with O. Reg 79/10 s. 114 (2), the license was required to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

A) The home’s policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-03-20, indicated that narcotics and controlled substances that are awaiting destruction were to be stored in a separate double locked stationary cupboard in a locked medication room.

A Critical Incident System (CIS) report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home’s investigation notes were reviewed by LTCH Inspector #561, and indicated that during an identified shift on an identified date, registered staff noted a discrepancy in the narcotic count. In an interview with the home, registered staff #103 who worked on that shift, removed incorrect doses of a narcotic prescribed to resident #001. There were two cards of the identified narcotic that were discontinued and two cards with the narcotic for regular administration. When the registered staff noticed the discrepancy they left the pills from the discontinued card in a medication cup in the top drawer of the medication cart. Then, they administered the correct dose to the resident from the narcotics that were prescribed for regular administration. The investigation notes stated that the registered staff indicated they had intentions to waste the medication that they removed from the discontinued card at shift change but forgot.

The clinical record review and the investigation notes indicated that the discontinued narcotics, were stored with the regular scheduled narcotics for administration in the narcotic bin of the medication cart for several days prior to the incident.

During the inspection, LTCH Inspector #561 interviewed registered staff #103. They stated that they removed the discontinued narcotics by mistake and noticed that there were two other cards with narcotics for regular administration. They placed the discontinued tablets in the top drawer of the medication cart in a medication cup and then they administered the regular dose from the card that was scheduled to be administered. The registered staff stated that they had intended to waste the discontinued narcotics with another registered staff but forgot to do it.

In an interview, the Senior Nursing Manager also acknowledged that the staff failed to comply with the home's policy related to the storage of narcotic and controlled substances awaiting destruction. The Senior Nursing Manager indicated that the narcotics from the discontinued cards should have been wasted right away instead of being left in the top drawer of the medication cart.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18.

B) The home's policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-03-20, indicated that all monitored drugs must be counted (jointly) at every shift change by two registered staff, one coming on shift and one going off shift, both will verify by signature the quantity of each monitored medication on hand with the Narcotic and Controlled Substance Administration Record (NSCAR).

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing / unaccounted for from the home.

The home's investigation notes were reviewed by LTCH Inspector #561, and indicated that on an identified date registered staff #103 failed to count the narcotics with the nurse at shift change and failed to count the narcotics with another nurse when they were leaving.

Registered staff #103 was interviewed by LTCH Inspector #561 and stated that they did not do the shift count of narcotics with the registered staff on the unit as that registered staff was behind and busy on the unit. They also stated that they did not count the narcotics at the end of their shift with another registered staff.

The Senior Nursing Manager was interviewed and acknowledged that the registered staff failed to complete narcotic counts on several shifts at shift change.

This area of non-compliance was identified during a Complaint Inspection, log # 018618-18.

C) The home's policy titled "Narcotics/Controlled/Monitored Drugs", Number 06-

03-20, indicated that the RN/RPN must count the monitored medication immediately upon opening the tamper proof bag and confirm quantity, documents the date, time and total quantity received from pharmacy and signs the top right hand corner of the Narcotic and Controlled Substance Administration Record (NCSAR). A second registered staff member witnesses and co-signs the NSCAR ensuring the count is correct and signing in both the top right corner and the "checked by" section of the NSCAR.

A CIS report was submitted to the Director on an identified date in 2018, indicating that a controlled substance was missing/unaccounted for in the home.

The home's investigation notes were reviewed by LTCH Inspector #561, and identified that on an identified shift, registered staff #109 received medications from the pharmacy including narcotics for resident #006. Narcotics for this resident included 20 individual medications for regular schedule and 20 for as needed (PRN) administration. There were four boxes together and a rubber band separated the regular from PRN medications providing two boxes of PRN medication.
The home's investigation notes indicated that when the registered staff received the medications they opened the sealed foil that contained the boxes and signed the narcotic sheet (NSCAR). The registered staff failed to open each individual box to count each medication. They assumed that all 10 medications were inside each box. Then, the registered staff gave the narcotics to another registered staff #110, on the unit where resident #006 resided. Registered staff #110 took the boxes, did not open them individually and signed the NSCAR indicating that all 10 ampules were present in each box. The registered staff did not do the count together.

The clinical record review indicated that the registered staff on the oncoming shift, counted the narcotics with registered staff #110 and found that one of the boxes of PRN narcotics had only eight medications in it. Two were missing. The packaging slip from the pharmacy indicated that there were 20 medications in total delivered to the home. The registered staff immediately reported this to the Manager on call.

Registered staff #109 was interviewed by LTCH Inspector #561 and stated that once they received the narcotics they failed to count them together with another

registered staff and that they did not open each individual box that contained the medications. They assumed that there were 10 medications in each box as indicated on the box.

Registered staff #110 was interviewed by LTCH Inspector #561 and stated that they failed to open each individual box to count how many medications were inside each box. They signed the NSCAR assuming all 20 medications were inside in the boxes marked PRN.

Both registered staff members acknowledged that they failed to follow the home’s policy and the best practice guidelines regarding handling of controlled substances.

In an interview, the Senior Nursing Manager acknowledged that the registered staff failed to follow the policy and failed to count the narcotics together and failed to open each individual box to count what was inside. The narcotics were not found and remain unaccounted for.

The licensee failed to ensure that their policy related to Narcotics/Controlled/Monitored Drugs was complied with.

This area of non-compliance was identified during a CIS Inspection, log #022668-18.

D) The home’s policy titled “Return from Hospital (Readmission)”, procedure #06-01-07, revised October 28, 2014, stated that upon re-admission registered staff were to review any documentation, process the hospital physician’s orders as listed on the transfer sheet, confirm orders with physician and fax the form to the pharmacy. The re-admission order form indicated that two registered staff signatures were required upon reconciliation of medications.

The Ministry of Health and Long Term Care, received a complaint log number 018039-18 on an identified date in 2018, related to medication administration.

The clinical records review indicated that on an identified date in 2018, resident #001 was readmitted to the home from the hospital with medication changes. The re-admission form was reviewed and indicated that one of the medications

was ordered as needed (PRN). The re-admission orders were confirmed by the physician when the resident returned. The Electronic Medication Administration Record (EMAR) was reviewed, and indicated that the re-admission order was added to the EMAR when resident returned as a regular scheduled medication and not PRN.

The home completed an investigation into the error and completed the medication incident report. The home's investigation notes stated that the registered staff did not complete a second check after re-admission and the error was not identified until several days later. The medication incident report stated that the registered staff entered the order on Point Click Care (PCC) as every four hours. The pharmacy did not send this order and had PRN order on their records. Resident received the medication as regular scheduled instead of PRN for several days.
The re-admission order form indicated that the second check of medication reconciliation was not completed by registered staff until several days after return.

Registered staff #102 was interviewed by LTCH Inspector #561 and stated that resident #001 received the medication as regular scheduled instead of PRN for several days.

In an interview, the Senior Nursing Manager acknowledged that resident received the wrong dose of the medication for several days until the error was identified. The Senior Nursing Manager stated that the home's process was to complete the re-admission order form to reconcile medications, confirm orders with the physician and a second check was required by registered staff when reviewing the medications orders. The Senior Nursing Manager acknowledged that the second check was not completed by registered staff upon re-admission.

This area of non-compliance was identified during a Complaint Inspection, log #s 016531-18, 018039-18, and 018618-18.

The severity of this issue was determined to be a level 2 as there was minimum harm/risk or potential for actual harm/risk to the resident. The scope of the issue was a level 2 as it related to several incidents. The home had a level 4 history as they had multiple NC with a Voluntary Plan of Correction (VPC) to the current

area of concern issued under this section on April 5, 2018 (2017_543561_0020 (A1) and on July 15, 2016 (2016_301561_0017). (561)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of November, 2018

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Daria Trzos

Service Area Office / Bureau régional de services : Hamilton Service Area Office