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 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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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 15, 2019	2019_703625_0003 (A1)	009099-18, 009508-18, 010252-18, 010264-18, 010266-18, 015344-18, 025425-18, 025649-18, 026240-18	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

Amended by KATHERINE BARCA (625) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Clarification was provided regarding co-related non-compliance. The judgement decision was included for CO #001.

Issued on this 15th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by KATHERINE BARCA (625) - (A1)

Amended 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): January 8 to 11, 14 to 18 and 22 to 25, 2019.

The following intakes were completed during this inspection:

- three logs related to Critical Incident System (CIS) reports regarding missing controlled substances for one resident;

- one log related to a CIS report regarding a missing controlled substance for one resident; and

- one log related to a CIS report regarding the provision of improper or incompetent treatment or care of a resident that resulted in a risk of harm to the resident.

Complaint inspection #2019_703625_0001 and Follow-up inspection #2019_703625_0002 were conducted concurrently with this CIS inspection.

Findings of non-compliance pursuant to the Long-Term Care Homes Act (LTCHA), 2007, s. 6 (1) (c) and Ontario Regulation (O. Reg.) 79/10, s. 131 (2) identified during this inspection have been issued in the Follow-Up report.

During the course of the inspection, the inspector(s) spoke with residents, family members, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the RAI Coordinator/Scheduling Clerk, PSWs from the Behavioural Supports Ontario Mobile Outreach Team, a Maintenance employee, the Environmental Services Supervisor, a Registered Dietitian (RD), Directors of Care (DOCs) and the Administrator.

The Inspectors also conducted observations of the care and services provided to residents, of resident to resident interactions, of staff to resident interactions, and of behaviours exhibited by residents. The Inspectors reviewed records including resident health care records (MED e-care progress notes, electronic Medication Administration Records (eMARs), electronic Treatment Administration Records (eTARs), care plans, Kardexes, quarterly Physician Reviews, hard copy Order Sheets and Progress Notes, etc.), email communication, home's investigation files, Narcotic/Controlled Drug Records, Narcotic/Controlled Drug Inventory Records, medication related safety reports, a Pharmacy Dispensing Error Report, topical drug audits, Dietary Reports, Flow Sheet reports, RPN 24 Hour Reports, portions of employee personnel files pertaining to staff qualifications, staff schedules and relevant licensee, home and pharmacy policies and procedures.

The following Inspection Protocols were used during this inspection:

Medication
Nutrition and Hydration

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

- **8 WN(s)**
- **2 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 has failed to ensure that, where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of the long-term care home to have, institute or

otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

O. Reg. 79/10, s. 114 (1) requires the licensee to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) requires the licensee to ensure that written policies and protocols are 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.

Three CIS reports were received by the Director on dates in the spring, summer and fall of 2018. The reports identified missing drugs from resident #002.

(a) Inspector #742 reviewed the homes policy "Guidelines for Use of [Transdermal Medication]", undated, which identified that staff were to document the date, time, and location of placement of transdermal medication on the MAR sheet.

The Inspector also reviewed Janzen's Pharmacy's policy "Medication Policies for Long-Term Care", revised September 2018, which indicated, in section 6.15, that staff were required to document administration and site patch placement on the MAR.

(i) A review of resident #002's health care record identified the following:
- a document titled Order Sheet and Progress Notes, dated the summer of 2018, which indicated staff were to provide a drug, and the that the drug had been provided to the resident on that date, at a specific time.
- a Narcotic/Controlled Drug Record which identified that the drug had been signed out for resident #002 on the same date and time listed on the Order Sheet and Progress Notes.
- the eMAR did not identify that the drug was provided to resident #002 on the date listed on the Order Sheet and Progress Notes and the Narcotic/Controlled Drug Record.

Inspector #625 interviewed DOC #101 regarding resident #002's drug not being documented as provided in the eMAR on a date in the summer of 2018, although the Narcotic/Control Drug Record shift count for the drug had decreased by one. The DOC acknowledged that the staff did not follow policy by not signing for the

drug as being provided to resident #002 in the eMAR.

(ii) The narcotic inventory record identified that a drug was signed out for resident #002 on another date in the summer of 2018, at a specific time. Documentation on the eMAR identified the drug had not been provided until the a specific time the following date.

Inspector #625 conducted an interview with DOC #101 who acknowledged the drug was recorded as provided on the eMAR on the date following its removal from the drug inventory, not on the date it was signed out from the inventory. The DOC reviewed the Narcotic/Controlled Drug Inventory Record, which indicated that the shift count for the drug was reduced by one on a specific date in the summer of 2018. The DOC acknowledged that staff did not follow the home's policy with respect to documenting the provision of the drug on the eMAR.

(b) Janzen's Pharmacy's policy "Medication Policies and Procedure for Long-Term Care", revised September 2018, indicated that medication administration errors were defined in the home's policies and procedures. The policy also directed staff to complete and submit a Medication Incident Report in the event a medication error occurred. The policy defined a wrong dose medication administration error as the administration of a dose of a medication that was greater or less than the amount ordered by the physician.

St. Joseph's Care Group (SJCG) policy "Client Safety Incident Reporting and Management - AD 6-30" approved January 1, 2018, defined an incident as an event, circumstance or outcome that occurred that was not planned or meant.

A review of resident #002's progress notes identified incidents involving the absence of the required drug for the resident, which had not been reported as medication incidents. Notes entered for multiple dates in the spring, summer and fall of 2018, identified the drug was not provided to the resident as required.

The incident reports provided by the licensee regarding resident #002 and their drug use, did not include incident reports corresponding to the previously identified progress notes.

During an interview by Inspector #625, RPN #113 acknowledged that a medication incident report was required each time the drug was not provided to resident #002.

During an interview with Inspectors #625 and #742, RN #107 acknowledged that an incident report was required to be submitted if the drug was not present during checks or was not provided to the resident.

In an interview by Inspector #625, RN #114 acknowledged that when a drug was missing or could not be located, an incident report should have been submitted as a medication incident had occurred, as the resident had not received the proper dose of the drug.

During an interview with Inspector #625, DOC #101 acknowledged that an incident report had not been submitted for the missing drug on a date in the spring of 2018. They also acknowledged that any time the drug was not provided to the resident, the resident was not receiving the required dose ordered by the Physician and a medication incident report was required.

(c) SJCG policy "Client Safety Incident Reporting and Management - AD 6-31" approved January 1, 2018, indicated staff were to document the disclosure of harm to a client in the clients' health record and in the electronic record.

A review of the internal incident report submitted on a date and time in the spring of 2018, identified a drug was reporting missing for resident #002. The report detailed actions taken by staff in response to the missing drug.

A review of resident #002's electronic progress notes identified no progress note that corresponded to the missing drug on the date identified in the internal incident report, in resident #002's health care record.

In an interview with Inspector #625, RN #107 acknowledged that staff were required to document an assessment of the resident in the progress notes when submitting internal incident reports.

In an interview with Inspector #625, DOC #101 acknowledged that there was no documentation in resident #002's progress notes which corresponded to the missing drug on the date identified in the internal incident report. The DOC further acknowledged that the internal incident report had identified resident #002 had not been provided with the drug for a specific period of time. [s. 8. (1) (b)]

2. A CIS report was submitted to the Director for a missing or unaccounted for

controlled substance. The report identified that the home was missing a drug for resident #003, which was identified missing by staff on a specific date and time in the spring of 2018.

(a) Inspector #625 reviewed the home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018. The policy identified the disposal of partial doses was to be witnessed by two nurses and, prior to discarding a narcotic that was drawn up in a syringe, the syringe and empty vial were to be shown to the co-signer. The policy also identified that wastage of narcotics was to be witnessed by two nurses, and that wastage was to be documented, witnessed and signed for on the Narcotic/Controlled Drug Record.

A review of the Narcotic/Controlled Drug Record from specific dates and times in the spring of 2018, identified multiple dates and times, involving multiple residents, where scheduled and prn (pro re nata or as needed) drug waste was documented without a co-signer's signature.

During interviews with the Administrator and DOC #102, they acknowledged multiple dates and times on the Narcotic/Controlled Drug Record which did not include a second nurse's signature, and which identified that staff had failed to follow the policy with respect to disposal of drug waste.

(b) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that when a partial dose of an certain type of drug was administered, the balance or contents were to be immediately discarded into a sharps container.

A review of resident #003's eMAR for a specific month in 2018 identified the resident was to receive a specific dose of a drug. The eMAR identified the resident received the dose on specific dates and times in the spring of 2018. The same staff member had signed that they had administered all of the doses previously referred to on the eMAR.

A review of the Narcotic/Controlled Drug Record, identified multiple entries where resident #003 had zero documented waste when waste was expected, on specific dates and times in the spring of 2018. One entry identified the dose was given more than once, the other identified one unit of the drug was signed out. Following these entries for resident #003, there was an absence of the next expected documented removal of the drug doses administered on the drug

record, although the eMAR identified the resident had received the subsequent doses.

During an interview with DOC #102, they acknowledged that only a specific number doses of the drug for resident #003 had been signed on the Narcotic/Controlled Drug Record, although the medication had been administered twice as many times. The DOC indicated that the home's policy had not been followed with respect to the expectations involving drug waste if the medication had been signed out once and used for multiple administration times.

(c) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that the Narcotic/Controlled Drug Count Record and the Narcotic/Controlled Drug Inventory Record were to be reviewed for accuracy after each entry.

A review of the Narcotic/Controlled Drug Inventory Record entry dated a specific date in the spring of 2018, identified resident #003's drug count as a specific number during consecutive counts.

The Narcotic/Controlled Drug Record reflected that resident #003 had a lower quantity of the drug present on the same date, at a time in between the times listed on the Narcotic/Controlled Drug Inventory Record.

Resident #003's eMAR for a month in 2018 listed administration times that date, which were consistent with the information on the Narcotic/Controlled Drug Record.

During interviews with the Administrator and DOC #102, they both acknowledged that the home's policy had not been followed with respect to registered staff verifying the count accurately for resident #003's drug on the specific date in the spring of 2018, for the second consecutive entry.

(d) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that all narcotics received from the pharmacy required two registered staff signatures on the Narcotic/Controlled Drug Inventory Record, and that two registered staff were required to review what was received and entered onto the inventory record.

The Narcotic/Controlled Drug Record identified an entry dated the spring of 2018,

at specific times, where a specific number of units of a drug were received from pharmacy for resident #003, which increased the number of drugs present from one specific value to another.

On the same date, the Narcotic/Controlled Drug Inventory Record listed one number of drug units present at a certain time, and another number present at the next time. The inventory record did not identify or contain an entry that reflected drugs were received from pharmacy, although the values listed increased by the same number of units listed on the Narcotic/Controlled Drug Record as received from the pharmacy.

During an interview with DOC #102, they acknowledged that registered staff had not followed the home's policy which required two staff to list all drugs of a specific characterisitic received from the pharmacy on the Narcotic/Controlled Drug Inventory Record.

(e) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that wastage of specific drugs was to be witnessed by two nurses, and that wastage was to be documented, witnessed and signed for on the Narcotic/Controlled Drug Record.

Janzen's Pharmacy's policy titled "Medication Policies and Procedures for Long-Term Care", revised September 2018, identified that nursing staff were to sign off electronically on the eMAR after a medication had been administered, including the unit dosage value if there was a dosage range.

The Narcotic/Controlled Drug Record identified a dose of a drug was signed out for resident #003 on a specific date and time in the spring of 2018, a specific dose of the drug was wasted, the count decreased by one unit, and the entry was signed by two staff. The drug record also listed a specific number of doses of the drug signed out for resident #003 on that date.

A review of the eMAR identified a specific number of doses of the drug of one characteristic signed as administered, but did not include documentation that the drug of a second characteristic was administered on the date listed on the Narcotic/Controlled Drug Record.

During interviews with DOC #102, they stated that registered staff were required to document the administration of the drug on the eMAR and acknowledged that

staff had not documented that the drug of a second characteristic had been administered on a specific date. The DOC acknowledged that the nursing staff had not followed the home's policies with respect to documenting the administration on the eMAR or, if the drug had not been administered but was disposed of, documenting that the drug was wasted on the drug record.

(f) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that, if a discrepancy was identified at shift count or during a shift, staff were required to completed a LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form and submit it to the Manager.

Inspector #625 reviewed the home's investigation file for resident #003's missing drug identified on a specific date and time in the spring of 2018. The file did not include a copy of the LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form.

During interviews with the Administrator, they stated they were not able to locate a completed LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form for the discrepancy.

(g) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that the Manager or Designate were required to review the Narcotic/Controlled Drug Record and the Narcotic/Controlled Drug Inventory Record on a monthly basis to determine if there were any discrepancies including missing signatures.

During an interview with DOC #102, they indicated that the home had not reviewed the Narcotic/Controlled Drug Count Record and Narcotic/Controlled Drug Inventory Record on a monthly basis to determine if there were any discrepancies, including missing signatures.

During an interview with DOC #101, they stated that they had been in the DOC position since a particular month in 2018 and had not completed any reviews of the Narcotic/Controlled Drug Record or the Narcotic/Controlled Drug Inventory Record during that time. [s. 8. (1) (b)]

3. A CIS report was submitted to the Director for a missing or unaccounted for controlled substance. The report identified that the home was missing one unit of a drug of a specific characteristic for resident #003, which was identified missing

by staff on a specific date and time in the spring of 2018.

The Inspector noted the intake referred to a second CIS report that had been submitted to the Director which identified one unit of a drug of a specific characteristic had also been identified as missing for resident #010 on the same date and time resident #003's drug was identified as missing, and that police had been notified of resident #010's missing drug.

(a) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that all shift counts were to be completed by two registered staff, one arriving for shift, and one completing shift; and that all registered staff were to remain on the unit until the count was completed.

A review of the Narcotic/Controlled Drug Inventory Record identified that only one registered staff member had signed for the shift change counts on a specific date in the spring of 2018, at two consecutive times, which was the date which the drugs were discovered missing for residents #003 and #010. The Inspector noted that 16 per cent of the entries reviewed from specific dates and times in the spring to summer of 2018, were missing the signature of the second registered staff member to indicate completion of the shift change count.

During an interview with DOC #102, they acknowledged that staff had not complied with the home's policy with respect to two staff signing the Narcotic/Controlled Drug Inventory Record, and specifically acknowledged that this had occurred on a specific date, at specific times, when drugs were noted missing for residents #003 and #010.

(b) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that registered staff arriving for shift were to count the narcotics and visually verify the number counted on the Narcotic/Controlled Drug Inventory; and the registered staff completing the shift were required to record, on the Narcotic/Controlled Drug Inventory Record, the number of narcotics counted and visually verify the number counted on the record.

During an interview with DOC #102, they acknowledged that staff had not followed the home's policy with respect to registered staff completing the shift record on the Narcotic/Controlled Drug Inventory Record, and specifically acknowledged that resident #010's drug count had been left blank on the a specific date and time in the spring of 2018, for the shift change count. [s. 8. (1)

(b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

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. (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. (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 has failed to ensure that 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 the assessments were integrated and were consistent with and complemented each other.

CIS reports were received by the Director on dates in the spring, summer, and fall of 2018. The reports identified missing drug of a certain characteristic from resident #002.

Inspectors #625 and #742 reviewed a Physician's order dated the spring of 2018, which included orders for the provision of a drug at a specific frequency. The Inspectors also reviewed Physician's Reviews dated the winter, spring, summer and fall of 2018, which instructed staff to verify that the drug was provided and to remove the previous drug prior to providing the new drug.

A review of the resident's progress notes by the Inspectors identified notes that contained inconsistent assessment of the number of drugs provided to the resident during checks in a month in 2018. The notes indicated that on a specific dates and times in the month, resident #002 had one number of drugs provided. On different specific dates and times, which fell within first set of dates and times, the notes identified the resident had a different number of drugs provided.

The Inspectors reviewed resident #002's eMAR for a month in 2018, which included an entry for the drug check and directed staff to verify the provision of the drug.

During an interview with RPN #113, they acknowledged that the assessment of the number of drugs provided to resident #002, were not consistent as the documentation identified there were two different amounts of the drug provided.

During an interview with RPN #116, they confirmed that they had documented the provision of the second number of drugs provided to resident #002, as they had incorrectly included the presence of another drug in the documentation.

During an interview with RN #114, they identified that staff may have misinterpreted drug checks to also include the resident's other drug. They acknowledged that the assessments of the resident having two different amounts of the drug provided, when only one number was ordered, could not both be accurate.

During an interview with Inspector #625, DOC #101 acknowledged that the staff assessments of the number of drugs provided to resident #002 in a month in 2018 were were not consistent with each other. [s. 6. (4) (a)]

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

A CIS report was submitted to the Director for an incident of improper or incompetent care of resident #008 which resulted in harm or a risk of harm to the resident on a date in the summer of 2018.

(a) The CIS report identified that resident #008 was administered a nutrition related intervention by RPN #111 on a date in the summer of 2018, which was not of the required consistency identified in the resident's plan of care. The report identified the resident required a specific consistency of liquids consumed using one device, while the RPN provided resident #008 the nutrition related intervention with a different device. The report identified RPN #106 observed the resident respond adversely, identified the nutrition related intervention was not the required consistency, and removed it from the resident.

Inspector #625 reviewed the home's investigation file related to the incident of improper or incompetent care provided to the resident on a specific date in the summer of 2018. Included was an interview with DOC #101 and RPN #106, dated the same date as the incident, where the RPN identified they had observed resident #008 the previous date, respond adversely to the nutrition related intervention, which they had been consuming with one device. The notes identified the liquid was not of the correct consistency and RPN #106 then instructed RPN #111 about the required fluid consistency, demonstrated how to acquire that consistency and stated that the nutrition-related intervention was to be provided with a certain device, as another device was not appropriate for the required fluid consistency. The interview notes also detailed that RPN #106 again observed resident #008 on the following date, with a the nutrition related intervention and the incorrect device, having difficulty consuming the item. The RPN again approached RPN #111 who stated they thought they had acquired the correct fluid consistency.

Inspector #625 reviewed resident #008's MED e-care progress notes including notes dated:
- a date in the summer of 2018, which identified resident #008 had been observed with a nutrition related intervention unsafely consumed, the writer observed the resident with the intervention provided with one device, not of the required consistency, and notified the resident's primary RPN that the consistency was incorrect; and

- the following date in the summer of 2018, which identified resident #008 was observed with a nutrition related intervention unsafely consumed, the intervention of an incorrect consistency was present, the correct consistency had been assessed by a Speech Language Pathologist (SLP) as a specific consistency, and that management was informed.

The Inspector reviewed resident #008's orders regarding fluid consistency in place at the time of the incidents, and noted the order in effect on both of the dates in the summer of 2018, was dated the previous month. The order instructed staff to discontinue one fluid consistency and initiate a second fluid consistency.

During an interview with RPN #106, they stated that they had observed resident #008 consuming a nutrition related intervention of an incorrect consistency provided by RPN #111 on two consecutive dates in the summer of 2018, and confirmed the details identified in their interview with DOC #101, dated the date of the second incident, in the summer of 2018.

During an interview with RD #103, they reported that, at the time of the incidents, resident #008 had been ordered fluids of one consistency and that the resident's plan of care had not been followed if the resident had been served fluids of a different consistency.

During an interview with DOC #101 they stated RPN #111 had provided resident #008 with the incorrect fluid consistency on two consecutive dates in the summer of 2018, acknowledged that the order in effect at that time identified the resident required a specific fluid consistency, and that the device the resident had been observed with could not be used to consume the fluid consistency the resident required.

(b) The CIS report also identified that, after resident #008 was administered a nutrition related intervention of an incorrect consistency by RPN #111 on a date in the summer of 2018, the resident was monitored for multiple days after the incident.

Inspector #625 reviewed an order by a RN (Extended Class) (EC) dated the date of the incident, which instructed staff to monitor resident #008 for certain characteristics, complete a monitoring related intervention at a specific frequency, and to notify the Physician or RN (EC) if the resident exhibited certain characteristics.

Inspector #625 reviewed a section of resident #008's health care record and could not locate the intervention entered for the resident in the month the incident occurred. The Inspector also reviewed MED e-care progress notes which included documentation of the intervention for the resident on the date of the incident (which did not reflect the complete intervention was performed), at a later time on the date of the incident, and on the date after the incident (which did not reflect the complete intervention was performed). The note dated the date after the incident identified the writer conducted an assessment of the resident the previous date.

During an interview with RPN #117, they reviewed the resident's health care record and confirmed the intervention had not been entered into MED e-care in one location on the date of the incident, or on the date following the incident, and the progress notes were entered with the intervention listed as indicated by the Inspector. The RPN acknowledged that documentation entered the day after the incident should have included documentation that the intervention was completed multiple times, but it only identified that that the intervention had been completed once.

During an interview with RN #107, they stated they would have provided resident #008 with the intervention at a particular time on the date of the incident, which is what they referred to when they documented actions that occurred the previous date. The RN acknowledged that the progress note entered the date after the incident, which listed the intervention was provided once, reflected all of the times they had completed the intervention up to the time the note was entered.

During an interview with DOC #101, they reviewed the order for the intervention at a specific frequency, for a specific duration, by the RN (EC) and reviewed the MED e-care progress notes that listed the times the intervention had been completed. The DOC stated that the orders were part of the resident's plan of care, that the resident should have had the intervention provided for the duration identified by the RN (EC), ending at a specific date and time, and that multiple interventions ordered were not completed if they had not been documented in a location in the health care record, or in the progress notes section. [s. 6. (7)]

3. On a date during the inspection, at a specific time, Inspectors #625 and #742 observed resident #004 request assistance with toileting while using a mobility aid.

Inspector #625 noted that the resident's falls prevention device was not engaged. In addition, the Inspector noted the device did not appear to be operational and it did not work when the Inspector tested it.

Inspector #625 reviewed resident #004's current care plan effective the fall of 2018, which identified the resident was at risk for falls, had previous injuries in previous years, and required a falls prevention device at all times when using their mobility aid.

During an interview with Inspector #625, PSW #118 acknowledged that resident #004's falls prevention device was not engaged or operational.

During an interview with PSW #119, they stated that they had provided resident #004 with a different falls prevention device and had disposed of the one observed by Inspector #625.

During an interview with RN #107, they stated that resident #004 required the falls prevention device when they used their mobility aid, and the device was required to be functional and engaged. [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 that ensures 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. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including restricting the access to all areas where drugs were stored to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

Ontario Regulation 79/10, s. (1) defines "topical" to mean a drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area to which it is applied.

On a date during the inspection, Inspector #625 observed resident #009's family member enter a numeric code to unlock a specific care cart. The family member then opened each drawer on the care cart. No staff were present during this time.

During an interview with resident #009's family member, they identified that they were not an employee of the licensee and stated they had the code to the care carts.

Inspector #625 identified that the specific care cart contained topical drugs for residents #011, #012, #013 and #014.

During an interview with PSW #120, they stated that family members should not

have the codes to the care carts and that the care carts contained topical drugs.

During an interview with PSW #121, they attended the specific care cart and acknowledged topical drugs were present for multiple residents.

During an interview with PSW #122, they stated that they were working with the residents assigned to the specific care cart that shift. The PSW stated they had not known that resident #009's family member had been in their care cart until informed by Inspector #625, and stated that resident #009 was not in their section. The PSW acknowledged that the care cart contained topical drugs.

During an interview with DOC #101, they stated that family members should not have the codes to care carts. The DOC attended the specific care cart with the Inspector and confirmed topical drugs were present. [s. 130. 2.]

2. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including undertaking a monthly audit of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

A CIS report was submitted to the Director for a missing or unaccounted for controlled substance. The report identified that the home was missing a drug for resident #003, which was identified missing by staff on a specific date and time in the spring of 2018.

During the inspection, Inspector #625 reviewed the Narcotic/Controlled Drug Inventory Records and Narcotic/Controlled Drug Records and identified multiple discrepancies. See WN #1, findings 2 and 3 for details.

The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that the Manager or Designate were required to review the Narcotic/Controlled Drug Record and the Narcotic/Controlled Drug Inventory Record on a monthly basis to determine if there were any discrepancies including missing signatures.

During an interview with DOC #102, they indicated that the home had not reviewed the Narcotic/Controlled Drug Count Record and Narcotic/Controlled Drug Inventory Record on a monthly basis to determine if there were any discrepancies, including missing signatures.

During an interview with DOC #101, they stated that they had been in the DOC position since a month in 2018, and had not completed any reviews of the Narcotic/Controlled Drug Record or the Narcotic/Controlled Drug Inventory Record during that time. [s. 130. 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 that ensures that steps are taken to ensure the security of the drug supply, including undertaking a monthly audit of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004, kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On a date during the inspection, Inspector #625 observed resident #009's family member enter a numeric code to unlock a care cart and open each drawer on the care cart. No staff were present during this time.

During an interview with resident #009's family member, they identified that they were not an employee of the licensee and stated they had the code to the care carts.

Inspector #625 identified that the specific care cart contained documents which included the personal health information (PHI) for residents in multiple rooms

such as incontinence product lists, a Dementia Observation System (DOS) document, Kardexes for mulitple residents, Behavioural Supports Ontario Mobile Outreach Team strategies for mulitple residents and restraint records. Throughout the inspection, the Inspector had noted that the PSW binders had been kept within the locked care carts, and had not observed staff to leave them unsecured, outside of the cart.

During an interview with PSW #120, they stated that family members should not have the codes to the care carts and that the care carts contained PSW binders with resident information in them.

During an interview with PSW #122, they stated that they were working with the residents assigned to the specific care cart that shift. The PSW stated they had not known that resident #009's family member had been in their care cart until informed by Inspector #625 and stated that resident #009 was not in that section. The PSW acknowledged that the care cart contained residents' PHI including restraint records and Kardexes.

During an interview with DOC #101, they stated that family members should not have the codes to care carts. The DOC attended the specific care cart with the Inspector and confirmed the PSW binder containing residents' PHI was present. [s. 3. (1) 11. iv.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

(a) On a date during the inspection, Inspectors #625 and #742 observed resident #004 request assistance from staff over a period of time. The Inspectors entered resident #004's room and observed the resident with their call bell inaccessible to the resident.

During an interview with the resident, they stated to Inspector #625, that they could not find their call bell. When the Inspector placed the call bell within the resident's reach, the resident reached for it and activated it.

During an interview with the Administrator on a date during the inspection, they acknowledged that resident #004's call bell would not have been accessible to the resident in the position it had been found in.

(b) On a second date during the inspection, Inspectors #625 and #742 observed resident #004 request assistance from staff. Inspector #742 had noted the resident had requested assistance from staff for a period of time. The Inspectors

entered the resident's room and observed the resident's call bell inaccessible to the resident.

During an interview with Inspector #625, PSW #119 acknowledged that resident #004's call bell had not been accessible to the resident in the location the Inspectors had observed it in.

(c) On a third date during the inspection, over a period of time, Inspector #625 observed resident #004 request assistance from staff. Inspector #625 entered the resident's room and observed the resident's call bell to be inaccessible to the resident.

During an interview with Inspector #625, PSW #123 confirmed that resident #004 could not reach the call bell in its current location and that they, and PSW #122, had assisted the resident in their room after lunch.

Inspector #625 reviewed resident #004's care plan effective a date in the fall of 2018, that identified resident #004 was to have a call bell within reach at all times when in their room.

During an interview with Inspector #625, DOC #101 stated that resident #004 should have their call bell in reach at all times, as identified in their care plan. [s. 17. (1) (a)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A CIS report was submitted to the Director for an incident of improper or incompetent care of resident #008 which resulted in harm or a risk of harm to the resident. The CIS report identified that resident #008 was administered a nutritional related intervention by RPN #111 on a date in the summer of 2018, which had not been the required consistency identified in the resident's plan of care. The report identified the resident required liquids of a specific consistency consumed with a particular device, while the RPN provided resident #008 the intervention with a different device. The report identified RPN #106 observed the resident respond adversely, identified the supplement was not the correct consistency and removed it from the resident. The CIS report did not identify that the resident's ordered fluid consistency at that time of the incident was a specific consistency, or that a similar incident involving the same resident and RPN #111 had occurred the previous day.

Refer to WN #2, finding 2 for details.

The Inspector reviewed resident #008's orders regarding fluid consistency in place at the time of the incidents and noted the resident was ordered a specific consistency at the time of the incidents, on two consecutive dates in the summer of 2018.

During an interview with RPN #106, they stated that they had observed resident #008 consuming a nutrition related intervention of an incorrect consistency provided by RPN #111 on two consecutive dates, in the summer of 2018.

During an interview with RD #103, they acknowledged that resident #008 had experienced two incidents where they had received the incorrect fluid consistency, on two dates in the summer of 2018, and that they should have received a different consistency at that time as ordered.

During an interview with DOC #101, they stated the RPN #111 had provided resident #008 with the incorrect fluid consistency on two consecutive dates, in the summer of 2018, and acknowledged that the order in effect at that time identified the resident required a specific consistency, although the report to the Director identified a different consistency was required. The DOC acknowledged that the Director had not been informed of the information related to the improper fluid consistency provided to the resident on the first date in the summer of 2018. [s. 24. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (4) The licensee shall cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title,
(a) a person who was required to be enrolled in a program described in clause (3) (c) or (d) if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired;
(b) a person who was required to be enrolled in a program described in clause (3) (f) if the person ceases to be enrolled in the program or fails to successfully complete the program by July 1, 2018; and
(c) a person who was required to be enrolled in a program described in clause (3) (c), (d) or (f) if the person fails to provide the licensee with proof of graduation from the program within 90 days of the graduation. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee has failed to cease to employ as a personal support worker, or as someone who provided personal support services, regardless of title, a person who was required to be enrolled in a program described in clause (3) (c), (d) or (f) if the person failed to provide the licensee with proof of graduation from the program within 90 days of the graduation.

During an interview with PSW #124, Inspector #742 identified that the employee had been scheduled to graduate from a nursing program in a previous year, was not employed as a nurse and was working in the home as a PSW.

On a date during the inspection, when the Administrator was asked to provide Inspectors #625 and #742 with PSW #124's qualification to work as a PSW in the home, they provided the Inspectors with a document titled Enrolment Verification from an educational institution dated the winter of 2017/2018, which identified the PSW was enrolled in the final year of a nursing program from a date in the summer of 2017 to a date in the spring of 2018.

Inspector #625 reviewed an Employee Activity Report for PSW #124, which identified the PSW began working for the licensee on a date in the spring of 2018, and continued to work through to 2019.

During an interview with Inspector #625 on a date during the inspecton, the

Administrator stated that they had spoken to the licensee's Human Resources department and PSW #124 was qualified to work as a PSW as they were a former nursing student and were waiting for their nursing licence from the College of Nurses of Ontario (CNO). The Administrator acknowledged that PSW #124 was no longer a student enrolled in the nursing program and had not yet registered with the CNO.

During a subsequent interview during the inspection, the Administrator provided Inspector #625 with an undated document from the CNO that listed PSW #124 was entitled to practise with no restrictions, but did not identify the class the PSW was registered under. Inspector #625 reviewed PSW #124's status on the CNO website with the Administrator. The CNO website identified the PSW had been registered as a type of nurse in the general class since the previous date. The Administrator acknowledged the PSW was hired in a month in 2018, graduated from the nursing program the following month, did not provide the licensee with proof of graduation, and continued to work in the home as a PSW without meeting the legislative requirements until they provided proof of registration with the CNO which was effective the previous date [multiple months after being hired]. [s. 47. (4) (c)]

WN #8: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that, when required to inform the Director of an incident under subsection (1), (3) or (3.1) the licensee, within 10 days of becoming aware of the incident, or sooner if required by the Director, the report made in writing to the Director set out, with respect to the incident, a description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

A CIS report was submitted to the Director for a missing or unaccounted for controlled substance. The report identified that the home was missing a drug for resident #003, which was identified missing by staff on a specific date and time in the spring of 2018. The report was amended days later, to inform the Director that the DOC had determined the missing drug had been administered to the resident two days before it was identified as missing by the home, but that it had not been documented on the "ledger".

Inspector #625 compared resident #003's eMAR to the Narcotic/Controlled Drug Record and noted that the documentation of administration of the drug was consistent between the two documents, including the documentation on the date the home identified the undocumented entry to have occurred.

The Inspector also noted that the Narcotic/Controlled Drug Inventory Record contained documentation that was inconsistent with the details identified in the eMAR and Narcotic/Controlled Drug Record with respect to the number of units of the drug present at a shift count on the date the home alleged the ledger was missing documentation. This discrepancy was inconsequential to the missing drug discovered two days later, as the previous and subsequent counts on the Narcotic/Controlled Drug Inventory Record were accurate when compared to the eMAR and to the Narcotic/Controlled Drug Record.

Additionally, the Inspector noted that the Narcotic/Controlled Drug Inventory Record and Narcotic/Controlled Drug Record for resident #003's drug failed to reconcile between two times on the date before the CIS report was submitted, when the drug inventory record identified one less unit was present at a specific time, than what the drug record indicated should have been present. The eMAR corroborated the documentation in the Narcotic/Controlled Substance Drug Record, supporting the number of units of the drug that should have been present, and that one unit was unaccounted for.

During an interview with the Administrator, they reviewed the relevant documents and acknowledged that the information provided to the Director had not been accurate when it identified the discrepancy was the result of a dose that was listed on the eMAR but had not been signed on out the drug record. The Administrator also acknowledged that, for the information in the CIS report to have been accurate in that the error occurred two days prior to it being identified by the home, each staff member that completed a change of shift drug count would have each made the same error and counted the actual number of units present incorrectly. The Administrator acknowledged that it was not likely that registered staff on multiple shift changes, who were required to have two registered staff count at each shift, had all made the same error in counting the number of units present. [s. 107. (4) 1.]

Issued on this 15th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KATHERINE BARCA (625) - (A1)
Inspection No. / No de l'inspection :	2019_703625_0003 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	009099-18, 009508-18, 010252-18, 010264-18, 010266-18, 015344-18, 025425-18, 025649-18, 026240-18 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 15, 2019(A1)
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Bethammi Nursing Home 63 Carrie Street, THUNDER BAY, ON, P7A-4J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janine Black

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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 :

(A1)
The licensee must be compliant with s. 8 (1) of O. Reg. 79/10.

The licensee shall ensure that, where the LTCHA, 2007, or O. Reg. 79/10 require the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, is complied with.

Specifically, the licensee must:
(a) Provide training to the home's registered nursing staff on the following policies, with emphasis on the areas of non-compliance identified in the grounds:
(i) the policy used in the home titled "Guidelines for Use of Fentanyl Patches (Duragesic)", undated;
(ii) Janzen's Pharmacy's policy "Medication Policies for Long-Term Care", revised September 2018, sections 5.9, Medication Administration Errors, and 6.15, Transdermal Medication Delivery (Patches);
(iii) the licensee's policy "Client Safety Incident Reporting and Management - AD 6-30" approved January 1, 2018;
(iv) the licensee's policy "Client Safety Incident Reporting and Management - AD 6-31" approved January 1, 2018; and
(v) the licensee's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018.
(b) Maintain records of the training provided, including the dates of the training,
the names and classifications of the staff who attended the training, the training content, and any other pertinent documents.
(c) Develop and implement an effective auditing process for the use of narcotic and controlled substances for residents, to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of the drugs, with a focus on the areas of non-compliance identified in the grounds.
(d) Maintain records of the audits conducted, including the dates of the audits, the names and classifications of the staff involved in the audits, the audit findings and corrective actions taken to address any deficiencies identified.

Grounds / Motifs :

1. The licensee has failed to ensure that, where the LTCHA, 2007, or O. Reg. 79/10 required the licensee of the long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

O. Reg. 79/10, s. 114 (1) requires the licensee to develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.

O. Reg. 79/10, s. 114 (2) requires the licensee to ensure that written policies and protocols are 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.

Three CIS reports were received by the Director on dates in the spring, summer and fall of 2018. The reports identified missing drugs from resident #002.

(a) Inspector #742 reviewed the homes policy "Guidelines for Use of [Transdermal Medication]", undated, which identified that staff were to document the date, time, and location of placement of transdermal medication on the MAR sheet.

The Inspector also reviewed Janzen's Pharmacy's policy "Medication Policies for Long-Term Care", revised September 2018, which indicated, in section 6.15, that staff were required to document administration and site patch placement on the MAR.

(i) A review of resident #002's health care record identified the following:
- a document titled Order Sheet and Progress Notes, dated the summer of 2018, which indicated staff were to provide a drug, and the that the drug had been provided to the resident on that date, at a specific time.
- a Narcotic/Controlled Drug Record which identified that the drug had been signed out for resident #002 on the same date and time listed on the Order Sheet and Progress Notes.
- the eMAR did not identify that the drug was provided to resident #002 on the date listed on the Order Sheet and Progress Notes and the Narcotic/Controlled Drug Record.

Inspector #625 interviewed DOC #101 regarding resident #002's drug not being documented as provided in the eMAR on a date in the summer of 2018, although the Narcotic/Control Drug Record shift count for the drug had decreased by one. The DOC acknowledged that the staff did not follow policy by not signing for the drug as being provided to resident #002 in the eMAR.

(ii) The narcotic inventory record identified that a drug was signed out for resident #002 on another date in the summer of 2018, at a specific time. Documentation on the eMAR identified the drug had not been provided until the a specific time the following date.

Inspector #625 conducted an interview with DOC #101 who acknowledged the drug was recorded as provided on the eMAR on the date following its removal from the drug inventory, not on the date it was signed out from the inventory. The DOC reviewed the Narcotic/Controlled Drug Inventory Record, which indicated that the shift count for the drug was reduced by one on a specific date in the summer of 2018. The DOC acknowledged that staff did not follow the home's policy with respect to documenting the provision of the drug on the eMAR.

(b) Janzen's Pharmacy's policy "Medication Policies and Procedure for Long-Term Care", revised September 2018, indicated that medication administration errors were defined in the home's policies and procedures. The policy also directed staff to complete and submit a Medication Incident Report in the event a medication error occurred. The policy defined a wrong dose medication administration error as the administration of a dose of a medication that was greater or less than the amount ordered by the physician.

St. Joseph's Care Group (SJCG) policy "Client Safety Incident Reporting and Management - AD 6-30" approved January 1, 2018, defined an incident as an event, circumstance or outcome that occurred that was not planned or meant.

A review of resident #002's progress notes identified incidents involving the absence of the required drug for the resident, which had not been reported as medication incidents. Notes entered for multiple dates in the spring, summer and fall of 2018, identified the drug was not provided to the resident as required.

The incident reports provided by the licensee regarding resident #002 and their drug

use, did not include incident reports corresponding to the previously identified progress notes.

During an interview by Inspector #625, RPN #113 acknowledged that a medication incident report was required each time the drug was not provided to resident #002.

During an interview with Inspectors #625 and #742, RN #107 acknowledged that an incident report was required to be submitted if the drug was not present during checks or was not provided to the resident.

In an interview by Inspector #625, RN #114 acknowledged that when a drug was missing or could not be located, an incident report should have been submitted as a medication incident had occurred, as the resident had not received the proper dose of the drug.

During an interview with Inspector #625, DOC #101 acknowledged that an incident report had not been submitted for the missing drug on a date in the spring of 2018. They also acknowledged that any time the drug was not provided to the resident, the resident was not receiving the required dose ordered by the Physician and a medication incident report was required.

(c) SJCG policy "Client Safety Incident Reporting and Management - AD 6-31" approved January 1, 2018, indicated staff were to document the disclosure of harm to a client in the clients' health record and in the electronic record.

A review of the internal incident report submitted on a date and time in the spring of 2018, identified a drug was reporting missing for resident #002. The report detailed actions taken by staff in response to the missing drug.

A review of resident #002's electronic progress notes identified no progress note that corresponded to the missing drug on the date identified in the internal incident report, in resident #002's health care record.

In an interview with Inspector #625, RN #107 acknowledged that staff were required to document an assessment of the resident in the progress notes when submitting internal incident reports.

In an interview with Inspector #625, DOC #101 acknowledged that there was no documentation in resident #002's progress notes which corresponded to the missing drug on the date identified in the internal incident report. The DOC further acknowledged that the internal incident report had identified resident #002 had not been provided with the drug for a specific period of time. (742)

2. A CIS report was submitted to the Director for a missing or unaccounted for controlled substance. The report identified that the home was missing a drug for resident #003, which was identified missing by staff on a specific date and time in the spring of 2018.

(a) Inspector #625 reviewed the home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018. The policy identified the disposal of partial doses was to be witnessed by two nurses and, prior to discarding a narcotic that was drawn up in a syringe, the syringe and empty vial were to be shown to the co-signer. The policy also identified that wastage of narcotics was to be witnessed by two nurses, and that wastage was to be documented, witnessed and signed for on the Narcotic/Controlled Drug Record.

A review of the Narcotic/Controlled Drug Record from specific dates and times in the spring of 2018, identified multiple dates and times, involving multiple residents, where scheduled and prn (pro re nata or as needed) drug waste was documented without a co-signer's signature.

During interviews with the Administrator and DOC #102, they acknowledged multiple dates and times on the Narcotic/Controlled Drug Record which did not include a second nurse's signature, and which identified that staff had failed to follow the policy with respect to disposal of drug waste.

(b) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that when a partial dose of an certain type of drug was administered, the balance or contents were to be immediately discarded into a sharps container.

A review of resident #003's eMAR for a specific month in 2018 identified the resident was to receive a specific dose of a drug. The eMAR identified the resident received the dose on specific dates and times in the spring of 2018. The same staff member had signed that they had administered all of the doses previously referred to on the

eMAR.

A review of the Narcotic/Controlled Drug Record, identified multiple entries where resident #003 had zero documented waste when waste was expected, on specific dates and times in the spring of 2018. One entry identified the dose was given more than once, the other identified one unit of the drug was signed out. Following these entries for resident #003, there was an absence of the next expected documented removal of the drug doses administered on the drug record, although the eMAR identified the resident had received the subsequent doses.

During an interview with DOC #102, they acknowledged that only a specific number doses of the drug for resident #003 had been signed on the Narcotic/Controlled Drug Record, although the medication had been administered twice as many times. The DOC indicated that the home's policy had not been followed with respect to the expectations involving drug waste if the medication had been signed out once and used for multiple administration times.

(c) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that the Narcotic/Controlled Drug Count Record and the Narcotic/Controlled Drug Inventory Record were to be reviewed for accuracy after each entry.

A review of the Narcotic/Controlled Drug Inventory Record entry dated a specific date in the spring of 2018, identified resident #003's drug count as a specific number during consecutive counts.

The Narcotic/Controlled Drug Record reflected that resident #003 had a lower quantity of the drug present on the same date, at a time in between the times listed on the Narcotic/Controlled Drug Inventory Record.

Resident #003's eMAR for a month in 2018 listed administration times that date, which were consistent with the information on the Narcotic/Controlled Drug Record.

During interviews with the Administrator and DOC #102, they both acknowledged that the home's policy had not been followed with respect to registered staff verifying the count accurately for resident #003's drug on the specific date in the spring of 2018, for the second consecutive entry.

(d) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that all narcotics received from the pharmacy required two registered staff signatures on the Narcotic/Controlled Drug Inventory Record, and that two registered staff were required to review what was received and entered onto the inventory record.

The Narcotic/Controlled Drug Record identified an entry dated the spring of 2018, at specific times, where a specific number of units of a drug were received from pharmacy for resident #003, which increased the number of drugs present from one specific value to another.

On the same date, the Narcotic/Controlled Drug Inventory Record listed one number of drug units present at a certain time, and another number present at the next time. The inventory record did not identify or contain an entry that reflected drugs were received from pharmacy, although the values listed increased by the same number of units listed on the Narcotic/Controlled Drug Record as received from the pharmacy.

During an interview with DOC #102, they acknowledged that registered staff had not followed the home's policy which required two staff to list all drugs of a specific characterisitic received from the pharmacy on the Narcotic/Controlled Drug Inventory Record.

(e) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that wastage of specific drugs was to be witnessed by two nurses, and that wastage was to be documented, witnessed and signed for on the Narcotic/Controlled Drug Record.

Janzen's Pharmacy's policy titled "Medication Policies and Procedures for Long-Term Care", revised September 2018, identified that nursing staff were to sign off electronically on the eMAR after a medication had been administered, including the unit dosage value if there was a dosage range.

The Narcotic/Controlled Drug Record identified a dose of a drug was signed out for resident #003 on a specific date and time in the spring of 2018, a specific dose of the drug was wasted, the count decreased by one unit, and the entry was signed by two staff. The drug record also listed a specific number of doses of the drug signed out

for resident #003 on that date.

A review of the eMAR identified a specific number of doses of the drug of one characteristic signed as administered, but did not include documentation that the drug of a second characteristic was administered on the date listed on the Narcotic/Controlled Drug Record.

During interviews with DOC #102, they stated that registered staff were required to document the administration of the drug on the eMAR and acknowledged that staff had not documented that the drug of a second characteristic had been administered on a specific date. The DOC acknowledged that the nursing staff had not followed the home's policies with respect to documenting the administration on the eMAR or, if the drug had not been administered but was disposed of, documenting that the drug was wasted on the drug record.

(f) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that, if a discrepancy was identified at shift count or during a shift, staff were required to completed a LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form and submit it to the Manager.

Inspector #625 reviewed the home's investigation file for resident #003's missing drug identified on a specific date and time in the spring of 2018. The file did not include a copy of the LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form.

During interviews with the Administrator, they stated they were not able to locate a completed LTC Narcotic and Controlled Drugs Count-Discrepancy Report Form for the discrepancy.

(g) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that the Manager or Designate were required to review the Narcotic/Controlled Drug Record and the Narcotic/Controlled Drug Inventory Record on a monthly basis to determine if there were any discrepancies including missing signatures.

During an interview with DOC #102, they indicated that the home had not reviewed the Narcotic/Controlled Drug Count Record and Narcotic/Controlled Drug Inventory

Record on a monthly basis to determine if there were any discrepancies, including missing signatures.

During an interview with DOC #101, they stated that they had been in the DOC position since a particular month in 2018 and had not completed any reviews of the Narcotic/Controlled Drug Record or the Narcotic/Controlled Drug Inventory Record during that time. (625)

(A1)
3. A CIS report was submitted to the Director for a missing or unaccounted for controlled substance. The report identified that the home was missing one vial of injectable hydromorphone for resident #003, which was identified missing by staff on June 16, 2018, at 1500 hours.

The Inspector noted the intake referred to a second CIS report had been submitted to the Director which identified one vial of injectable morphine had also been identified as missing for resident #010 on July 16, 2018, at 1500 hours, and that police had been notified of this missing drug.

(a) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that all shift counts were to be completed by two registered staff, one arriving for shift, and one completing shift; and that all registered staff were to remain on the unit until the count was completed.

A review of the Narcotic/Controlled Drug Inventory Record identified that only one registered staff member had signed for the shift change counts on June 16 at 0700 hours and at 1530 hours, the date which the two vials of hydromorphone were discovered missing for residents #003 and #010. The Inspector noted that, seven out of 44, or 16 per cent, of the entries reviewed from June 10 at 0600 hours to June 23 at 0700 hours, were missing the signature of the second registered staff member to indicate completion of the shift change count.

During an interview with DOC #102, they acknowledged that staff had not complied with the home's policy with respect to two staff signing the Narcotic/Controlled Drug Inventory Record, and specifically acknowledged that this had occurred on June 16 at 0700 hours and June 16 at 1520 hours, when hydromorphone was noted missing for residents #003 and #010.

(b) The home's policy "Narcotic and Controlled Drug Control (LTC) – LTC 11-10", approved June 2018, identified that registered staff arriving for shift were to count the narcotics and visually verify the number counted on the Narcotic/Controlled Drug Inventory; and the registered staff completing the shift were required to record, on the Narcotic/Controlled Drug Inventory Record, the number of narcotics counted and visually verify the number counted on the record.

During an interview with DOC #102, they acknowledged that staff had not followed the home's policy with respect to registered staff completing the shift record on the Narcotic/Controlled Drug Inventory Record, and specifically acknowledged that resident #010's prn hydromorphone count had been left blank on the June 16, 2018, 1520 hours shift change count.

The decision to issue this compliance order was based on the severity level 2, as there was the potential for actual harm to occur to residents. The scope level 3 was indicated as problems causing the deficiency were pervasive in the home, with respect to the home's failure to comply with its medication management policies. The home has a compliance history specific to this area of the legislation where a voluntary plan of correction was issued during inspection #2018_703625_0001 on March 26, 2018, related to responsive behaviours. (625)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 05, 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:

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

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

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

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

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

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 February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by KATHERINE BARCA (625) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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