Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 23, 2018	2018_617148_0009	005324-18	Resident Quality Inspection

Licensee/Titulaire de permis

The Glebe Centre Incorporated
950 Bank Street OTTAWA ON K1S 5G6

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

Glebe Centre
950 Bank Street OTTAWA ON K1S 5G6

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

AMANDA NIXON (148), GILLIAN CHAMBERLIN (593), MICHELLE EDWARDS (655)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 21, 22, 23, 26, 27 and 28 and April 3, 4 and 5, 2018.

This inspection included two critical incidents reports (CIR) related to the medication management system.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Director of Care, the Manager of Nursing Care Operations, Executive Assistant, Director of Quality Management, Director of Resident Services, Social Worker, Pharmacy Consultant, Quality Improvement Nurse, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Family Council Representative and Residents.

The inspectors reviewed resident health care records, documents related to the medication management system, resident and family councils, policies and procedures as required and the licensee's investigation documents related to the above identified CIRs. In addition, the inspectors toured resident care areas in the home and observed infection control practices and medication administration, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

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

7 WN(s)
5 VPC(s)
2 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	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

The licensee failed to ensure that where the Act or 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 plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, s. 136 (2) 2, the licensee's drug destruction and disposal policy must provide for the following:

That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Specifically, the licensee failed to ensure that the licensee's policy titled "Drug Destruction and Disposal" (8-01), revised in 2011, was complied with.

According to the policy titled "Drug Destruction and Disposal" (8-01), a surplus of prescribed drugs (those remaining in containers labeled with the name of a resident) can occur when the drug has been discontinued by the Attending Physician. In the policy, it is indicated that surplus drugs are rendered unusable on-site. According to the same policy, narcotics or other controlled substances that are to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Over the course of the inspection, registered nursing staff (RPN #127, RPN#126, RPN #125) described the processes in place related to the disposal of controlled substances. According to nursing staff, two staff members are required to, together, remove a resident 's supply of narcotic or other controlled substance from the residents' supplies in the medication cart, and place it in a separate storage bin when the order for that narcotic or controlled substance has been discontinued.

i. A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Home's Act, 2007, related to a missing or unaccounted for controlled substance. According to the CIR, it was discovered by a member of the registered nursing staff on a specified date that a specific quantity of a specified controlled substance was missing. The controlled substance was ordered for resident # 045 and subsequently discontinued, after which time the staff member who discovered the incident identified a discrepancy in the documentation such that the medication was not identified on the count sheet as being discontinued.

Inspector #655 reviewed the health care record belonging to resident #045. According to the physician's orders, resident #045 was to receive a specified dose of the above-noted controlled substance at a specified frequency when needed. According to the order-history, the order was started on a specified date; and was discontinued five days later - approximately one week before the resident's supply of the controlled substance was found to be missing. According to the CIR, RPN #126 was one of two nurses whose signature was on the related Count sheet.

During an interview, RPN #126 recalled an incident in which an unspecified quantity of a specific controlled substance went missing in a specified month on resident # 045's home area. RPN #126 recalled that at that time, the controlled substance which had belonged to a specific resident had been discontinued. RPN #126 recalled counting that resident's supply of the controlled substance, and leaving it in the cart, even after the drug had been discontinued from the resident's drug regime. During the interview, RPN #126 indicated to Inspector #655 that the resident's supply of the specified controlled substance remained in the medication cart for an unspecified period of time after it was discontinued because it was difficult to find the time required to allow for two registered nursing staff members to dispose of the drug together.

During the inspection, Inspector #655 was provided with a copy of the investigation notes related to the above-described incident by the DOC. The investigation file included the

documents titled "Surplus Prescribed Drugs" and "Narcotic/Controlled Substances Surplus Drugs". According to the DOC, a record of all destroyed drugs was expected to be maintained by documenting each destroyed drug on one of the above-noted forms. Inspector #655 reviewed both forms, and found no documentation that was indicative that the supply of the controlled substance that was previously prescribed for resident #045 had been destroyed. According to the DOC, the specified quantity of the controlled substance was never accounted for.

ii. A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

During the inspection, Inspector #655 reviewed the licensee's internal investigation notes related to the above-noted incident. As a result of the internal investigation, numerous discrepancies in RN #128's documentation and practices were identified over a seven month period. According to the internal investigation notes, RN #128 was removing controlled substances from numerous residents' supplies. One such resident was resident #049.

Inspector #655 reviewed the health care record belonging to resident #049. According to the physician's order- history, resident #049 was prescribed a specified controlled substance on a specified date. According to the order-history, this order was discontinued on a specified date, and subsequently re-ordered approximately three months later. There was no order in place for resident #049 related to the use of the controlled substance during that three month period.

As part of the internal investigation file, Inspector #655 was provided with copies of the Narcotic and Controlled Drug Administration Record for resident #049. The Narcotic and Controlled Drug Administration Record for resident #049, as indicated on the form, was for the same controlled substance that had been discontinued, as described above.

According to the documentation on the Narcotic and Controlled Drug Administration Record for resident #049, doses of the controlled substance were administered on thirteen separate occasions over a period of eight days, although there were no orders for the controlled substance for resident #049 during that time.

In four of the thirteen instances, there is a written notation indicating that the controlled

substance was removed from resident #049's supply to be given to resident #051. According to the licensee's internal investigation notes, there was no indication in the resident's eMAR that the controlled substance had actually been given as indicated on the resident's Narcotic and Controlled Drug Administration Record.

Inspector #655 also reviewed the documentation on a Ward Drug Count sheet (which also included counts of controlled substances), for resident #049's resident home area for a specified period. The Narcotic Ward Drug Count sheets included a count for the above-described controlled substance belonging to resident #049, although it had been discontinued.

During an interview, the DOC indicated that resident #049's supply of the specified controlled substance was retained after it was discontinued on a specified date.

The licensee failed to ensure that the licensee's policy titled "Drug Destruction and Disposal" (8-01), revised in 2011, was complied with.

1. In accordance with O. Reg. 79/10, s. 123 (b), every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

Specifically, the licensee failed to ensure that the policy titled "Drug Storage" "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008, provided to Inspector #655 by the DOC, was complied with.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

i. According to the policy titled "Drug Storage", "Contingency/Emergency Supply" (#6-02), where a narcotic is used from the emergency/contingency supply, only one vial or dose is to be signed out at a time.

Inspector #655 reviewed the licensee's internal investigation notes related to the above-described incident. According to the investigation notes, RN #128 removed more than

one vial of the narcotic, hydromorphone (injectable formula), at one time from emergency/contingency supplies in the home on four separate occasions within a three month period:

- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Emergency/Contingency Supply located on Lindenwood,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Emergency/Contingency Supply located on Woodlawn,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Emergency/Contingency Supply located on Lindenwood; and,
- On a specified date, RN #128 removed 3 vials of hydromorphone injectable from the Woodland Emergency/Contingency Supply.

According to the documentation, four vials that were taken from the above-noted emergency supplies during a specified month were to be used for resident #047. Inspector #655 reviewed the health care record belonging to resident #047 and found there was, at no time in the specified month, an order for hydromorphine injectable for resident #047.

During an interview, RPN #125 recalled two incidents which occurred in a specified month where a member of the registered nursing staff had removed two or three hydromorphone injectables from one of the emergency supply stocks at one time. RPN #125 indicated to Inspector #655 that there had been no restrictions in place with regards to the amount of a narcotic that could be removed from an emergency supply stock at one time, noting that if a resident is to receive a narcotic every hour, a staff member may choose to remove several doses or vials from the emergency stock at one time.

During an interview, the DOC indicated to Inspector #655 that the policy titled "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008, was in place at the time of the above-described incidents; and that staff were expected to remove only one vial or dose of a narcotic, such as hydromorphone, from the emergency supply at one time.

ii. In the same policy "Drug Storage", "Contingency/Emergency Supply" (#6-02), designated storage locations for the emergency supply of the narcotic, hydromorphone, are identified. According to the policy, hydromorphone is to be stored in emergency supply stocks located on Glebewood and Queenswood units. The other emergency supply storage locations (Lindenwood and Woodlawn) were not designated for the

storage of hydromorphone.

Inspector #655 reviewed the licensee's internal investigation notes related to the critical incident, as described in part (i) of the finding.

According to the investigation notes, RN #128 removed a total of 9 hydromorphone injectables (vials) from emergency supply stocks located in the undesignated storage areas of Lindenwood and Woodlawn over a three month period:

- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Lindenwood emergency supply stock,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Woodlawn emergency supply stock,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Lindenwood emergency supply stock; and,
- On a specified date, RN #128 removed 3 vials of hydromorphone injectable from the Woodland emergency supply stock.

During an interview, the nurse auditor for the pharmacy service provider indicated to Inspector #655 that the narcotic, hydromorphone, had always been stored in all of the emergency supply stock locations (a total of five locations) in the home up until a specified date, at which time it was decided that the narcotic would only be stored in two designated emergency supply stock areas in the home. The nurse auditor indicted to Inspector #655 that they had been working in this role for two years.

During an interview, the DOC indicated to Inspector #655 that prior to the investigation into the CI they had not been aware that hydromorphone was being stored in the undesignated areas, emergency supply stock locations located on Woodlawn and Lindenwood.

Over the course of the inspection, the DOC indicated to Inspector #655 that over the six month period in which the misappropriation of controlled substances had occurred, there had been no mechanisms in place whereby compliance with the licensee's medication management system policies could be evaluated.

The licensee failed to ensure that the policies, "Drug Destruction and Disposal" (#8-01) and "Drug Storage – "Contingency/Emergency Supply" (#6-02), were complied with. (Log 023240-17)

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 any plan, policy, protocol, procedure, strategy or system, related to the medication management system is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall 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. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of medications taken from alternate drug supplies and the accurate destruction and disposal of drugs.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

During the inspection, Inspector #655 was provided with a copy of a Health Canada document titled "Loss or Theft Report Form for Controlled Substances and Precursors". On that form, under "List of controlled substances - precursors lost or stolen" the following items are identified as being lost or stolen:
- 85 vials of midazolam injectables (5mg/ml), and an additional 19 vials of midazolam

injectables allegedly broken or destroyed,
- 28 vials of hydromorphone injectables (2mg/ml); and,
- 8 hydromorphone (1 mg) tablets.

In the CIR, it is further indicated that RPN #127 admitted that they had signed as a witness for 10 broken vials of of a specified controlled substance when asked to do so by RN #128 on a specified date.

According to the CIR, RPN #127 agreed to sign as a witness without having seen the broken vials; and when the event happened three days earlier.

During an interview, RPN #127 confirmed that they had signed as a witness without having observed the waste, noting that RN#128 had initially wasted the medication without obtaining a witness.

In addition, the licensee's internal investigation into the incident involved a review of seven residents' Narcotic and Controlled Substances Administration Records. As a result, discrepancies were identified including numerous transfers of resident-assigned controlled substances, and unwitnessed wasting of medications.

Inspector #655 reviewed the Narcotic and Controlled Drug Administration Records (the record) belonging to one of the seven residents', resident #048. The medication identified on each of the records for resident #048 was a specified controlled substance. The directions, according to the record were to administer the drug at a specified frequency when needed. According to the documentation on resident #048's record, a dose of the controlled substance was removed from resident #048's medication supply a total of 53 times over a six week period.

On the same record for resident #048, there is a written notation on 22 of the 53 occasions which indicates that the dose was removed from resident #048's medication supply to be administered to a co-resident. Most frequently, the co-resident is identified as being resident #051.
According to the licensee's internal investigation notes, which included a copy of resident #051's MAR, the documentation in resident #051's MAR was not consistent with the documentation on resident #048's Narcotic and Controlled Substance Administration Record in that there was no indication on resident #051's MAR that the resident had received the medication that was removed from resident #048's medication supply on the following dates: June 7, 12, 14, 16, 19, 22, 25, and 29, 2017; and, July 3, 4, 5, 6, 8, and

9, 2017.

On the same record for resident #048, a written notation in four instances is indicative that a vial of the controlled substance was wasted (broken or destroyed); though there was no witness signature found on the record.

During an interview, RPN#125 recalled several instances in which a specific nurse had removed controlled substances from a resident or emergency/contingency supply for the purpose of administering the medication to a resident who resided in another resident home area. According to RPN #125 there had been no policy or protocol in place to ensure that the medication was administered to the co-resident on another resident home area, as was indicated by the nurse at the time.

Over the course of the inspection, the DOC indicated to Inspector #655 that signing for a wasted medication without seeing the waste, the practice of wasting a controlled substance without a witness, and the practice of transferring resident-assigned controlled substances is not consistent with practice expectations. According to the DOC, residents who regularly require a specified medication, would be expected to have an order and thus their own supply available; and in other specific circumstances, staff would be expected to access the emergency/contingency medication supplies as opposed to other resident-assigned medications. At the same time, the DOC indicated to Inspector #655 that there had been no written policy or protocol in place which outlined the above-noted expectations related to obtaining a witness-signature for wasted medications; or with regards to the transferring of resident assigned medications.

The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of medications taken from supplies that did not belong to the receiving resident; and the accurate destruction and disposal of wasted drugs.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care is based on an assessment of the resident and the resident's needs and preferences and that the plan of care provides clear direction to direct staff.

Resident #004 requires total care for activities of daily living. The resident was observed by the Inspector to have a lap belt applied on two occasions. On March 22, 2018, the resident was observed to be seated in a wheelchair with a lap belt applied and slight tilt applied to the wheelchair. On March 26, 2018, the resident was observed to be seated in a wheelchair while at the dining room table with a lap belt applied. Later that same

morning the resident was observed in a common space with the lap belt removed and slight tilt applied. On March 22, 2018, the resident's bed system was observed to have two bed rails in the up position.

In review of the health care record for resident #004, the most recent Minimum Data Set (MDS) Assessment and plan of care indicated the use of two side rails up when in bed for safety under the care item of falls. The use of a lap belt was not noted in the current plan of care accessed by direct care staff or the most recent MDS assessment, however, the physician orders included the use of a lap belt for safety.

The Inspector interviewed PSW #109, who was responsible for the care of resident #004 and who identified as being familiar with the resident's care. When asked, PSW #109 said that the belt had been applied after morning care as PSW #109 needed to attend to a co-resident in another room and the lap belt is applied when resident #004 is left unattended. PSW #109 said that the resident leans to the side and can slide in the chair and the lap belt is to keep the resident from sliding in the chair or slouching. When asked about when the lap belt is applied, PSW #109 reported that the lap belt will be put on when the resident is unattended, PSW #109 clarified that the lap belt should have been removed while at the dining table. When discussed, the PSW was not aware of any written direction with regards to the use of the lap belt. PSW #109 noted that the resident has a rest period in bed during the early afternoon to which both side rails are applied. PSW #109 reported that resident #004 is able to move minimally in bed but not enough that the resident would be at risk of falling or rolling out of bed. When asked what the purpose of the side rails were, PSW #109 reported that the side rails were to keep the resident in the bed. PSW #109 said that the resident does not attempt to leave the bed or chair and requires assistance for all positioning.

Inspector #148 spoke with RPN #111, who identified as being familiar with the resident's care. RPN #111 reported that the lap belt was previously used as it related to the resident's aggressive behaviours. Furthermore, due to a decrease in health status and change in behavioural management strategies the resident's behaviours have improved. RPN #111 said that at this time the lap belt is more so used to maintain the resident's upright posture as the resident may lean to the side, lean forward or slide in the chair. When the physician order was reviewed, RPN #111 reported that the wheelchair's tilt is the preferred method to maintain the resident posture. When asked when the belt is applied, the RPN said that it is applied when the resident is out of sight or when the chair is upright. The RPN said that if the tilt is applied then the lap belt is not needed, nor is it required if the resident is not agitated or the resident is sitting in an area where other staff

are present. In a separate interview with RN #110, it was reported that the tilt is the preferred method to maintain the resident's posture; the RN exampled the lap belt would be applied when the chair is upright. As it relates to the use of the bed rails, RPN #111 said that both bed rails are in use when the resident is in bed, however, the resident no longer moves in bed as the resident once did. In discussion about the use of the bed rails, the RPN said that it is likely that the resident does not need the rails anymore as the RPN does not believe the resident is at risk of falling off the bed nor does the resident participate in repositioning. RN #110 said that the bed rails are not used by the resident for safety or repositioning at this time.

The use of side rails for resident #004 is not based on the resident's current needs and preferences and at this time there is no clear direction for staff providing direct care, on the application of the lap belt.

The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #043 has had a decline in continence status. In review of the most recent MDS assessment the resident is occasionally incontinent of bladder and uses a pad. Documentation maintained by PSW staff indicate that in the last 14 days the resident has had episodes of incontinence on all shifts. The plan of care describes the resident as continent and self-toilets.

The Inspector spoke with PSW #105, who is the regular PSW who cares for this resident. PSW #105 said that the resident is able to self-toilet and that the resident may go to the toilet but may not void due to the resident's confusion. PSW #105 reported that the resident wears pull ups at this time. When asked about continence care, PSW #105 said that the resident is checked for wetness three times during the day shift. The PSW reported that the resident is usually slightly wet in the morning when rising from bed but generally dry during the day shift. When asked where staff would find information related to the continence care needs of this resident, PSW #105 indicated that it would be in the plan of care at the nursing station. The plan of care was reviewed in the presence of PSW #105, which described the resident as continent.

The plan of care, as it relates to continence care for resident #043's, is not based on an assessment of the resident and the resident's needs.

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 based on an assessment of the resident and the needs and preferences of that resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

The licensee has failed to ensure that only drugs approved by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care, and the Administrator are kept for the purpose of the emergency drug supply.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related

to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

According to the CIR, RPN #125 reported to the DOC that on a specified date, and again three days later, RN #128 removed two and then three vials, respectively, of hydromorphone injectables (2 mg/ml) from the emergency supply box located on Woodlawn.

During an interview, RPN #125 also recalled two incidents which occurred in a specified month where a member of the registered nursing staff had removed two or three hydromorphone injectables from one of the emergency supply stocks.

During the inspection, Inspector #655 was provided with a policy titled "Drug Storage", "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008. According to the policy, the storage of hydromorphone in the emergency supply stocks located on two designated units - Glebewood and Queenswood - was approved. According to the same policy, Woodlawn was not a designated storage area for an emergency supply of hydromorphone; neither was Lindenwood. According to the DOC, this policy was in place at the time of the incident.

Inspector #655 reviewed the licensee's internal investigation notes related to the above-described incidents. According to the investigation notes, RN #128 was found to have removed hydromorphone from either the Woodlawn or the Lindenwood emergency supply stocks - undesignated storage areas, on four separate dates.

During an interview, the nurse auditor from the pharmacy service provider indicated to Inspector #655 that the hydromorphone had been stored in all contingency/emergency supply locations (five areas) in the home up until a specified date, at which time a decision was made to restrict the storage of hydromorphone to two designate areas in the home.

During an interview, the DOC indicated to Inspector #655 that the nurse auditor from the pharmacy service provider had placed a supply of the narcotic, hydromorphone, in the Woodland and Lindenwood Emergency Supply stocks based on an assumption that it was intended to be stored there, without their knowledge. At the same time, the DOC further confirmed that the above-described policy, "Drug Storage", "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008, was in place at

the time.

The licensee has failed to ensure that only drugs approved by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care (DOC), and the Administrator are kept for the purpose of the emergency drug supply, when hydromorphone was kept in two undesignated emergency drug supply storage areas without the knowledge of the DOC and the Administrator.
(Log 020987-17)

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where a home maintains an emergency drug supply, that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug was prescribed for the resident.

During the inspection, Inspector #655 reviewed the most recent quarterly review meeting minutes (Pharmacy and Therapeutics Committee Meeting), which took place on March 5, 2018. According to the minutes, an administration error occurred in a specified month,

which involved a resident and a high-risk medication – a specified controlled substance.

Inspector #655 reviewed the internal medication incident report related to the above-noted incident.

According to the internal medication incident report, on a specified date, resident #050 was given a specified controlled substance in error, instead of a controlled substance which had been prescribed to the resident. According to the medication incident report, resident #050 was known to be allergic to the controlled substance that was given in error at the time.

Inspector #655 reviewed the health care record, including progress notes, belonging to resident #050. In an entry dated the same day as the above-described incident, created by RN #124, it is indicated that resident #050 was given a specified controlled substance, to which the resident was allergic to. In the same note, it states that the original order was for another specified controlled substance.

During an interview, RN #124 recalled the incident as described above. RN #124 indicated that on the date of the incident, they conducted the shift-change count of controlled substances and noted that there was a specified controlled substance in this resident's medication supply. At the same time, RN #124 recalled that at the beginning of the shift that day, they reviewed the health care record belonging to resident #050 in order to determine whether there had been any new orders or changes to the resident's plan of care. According to RN #124, at that time it was found that an order set was implemented for resident #050. On review of the order-set, RN #124 observed that there was an order for a controlled substance (the same medication that was given to resident #050 in error) on the order set through which a line had been drawn, with a handwritten note which read "error". On the same order-set was an order for the other controlled substance, which on the day of the incident resident #050 was intended to receive. RN #124 further recalled that at that time, they reviewed the eMAR for resident #050 and noted that the order for the controlled substance which had been crossed out had been entered into the eMAR, and not the other order. RN #124 indicated that by that time, resident #050 had already been given a dose of the incorrect medication. RN#124 indicated to Inspector #655 that when the physician was called, the physician indicated that resident #050 was not to receive the medication that had been crossed out because the resident was allergic to it.

The licensee has failed to ensure that no drug was administered to resident #050, unless

the drug was prescribed for the resident, when resident #050 was given hydromorphone instead of morphine.

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

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 :

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, the incident occurred on a specified date - approximately two weeks before it was reported to the Director under the Long-term Care Homes Act, 2007. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

During the inspection, the DOC provided Inspector #655 with the licensee's internal

investigation notes related to above-noted critical incident.

On review of the investigation notes, it was determined that on a specified date, the suspected irregularities in RN #128's medication handling practices and possible misappropriation of controlled drugs was reported internally to management in the home, at which time an investigation was initiated. According to the investigation notes, the police were notified of the incident ten days after it was initially reported internally; and Health Canada was notified on eleven days after it was initially reported internally.

According to a Health Canada document, provided to Inspector #655 with the investigation notes, titled "Loss or Theft Report Form for Controlled Substances and Precursors", the following controlled substances were identified as being "lost or stolen":

- 85 vials of midazolam injectables (5mg/ml), and additional 19 midazaolam vials allegedly broken or
destroyed,
- 28 vials of hydromorphone injectables (2mg/ml); and,
- Eight hydromorphone tablets (1 mg).

The Health Canada Document was dated a specified date – five days before the incident was reported to the Director under the Long-term Care Homes Act, 2007.

Inspector #655 was unable to locate any documentation that would indicate that the incident had been reported to the Director under the Long-term Care Homes Act, 2007, at any time earlier.

The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident.
(Log 020987-17)

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and, that all medication incidents and adverse drug reactions are reviewed and analyzed.

During the inspection, Inspector #655 reviewed the internal medication incident report for a medication incident which occurred on a specified date, where resident #050 was given a specified medication in error. Resident #050 was known to be allergic to the medication, a controlled substance, which was given in error. (Refer to WN #5)

On review of the internal medication incident report, Inspector #655 found no record of the immediate actions taken to assess and maintain the resident's health; nor was there any indication that the incident had been reviewed or analyzed.

During an interview, RN #124 recalled the above-noted medication incident (refer to WN #5). At the time of the interview, RN #124 indicated to Inspector #655 that they had

documented the medication incident on the medication incident form; but had not documented it together with a record of the immediate actions taken to assess and maintain the resident’s health. RN #124 indicated to Inspector #655 that any immediate actions that were taken were documented separately, in the resident’s progress notes.

During an interview, the DOC indicated to Inspector #655 that when a medication incident occurs, it is expected that the incident be documented, together with a record of the immediate actions taken to assess and maintain the resident’s health, on the internal medication incident report form. At the same time, the DOC indicated that the DOC or designate (Manager of Nursing Care Operations #102) normally reviews and analyzes each medication incident. According to the DOC, this process is documented on the medication incident report form; and a signature at the bottom of the incident report document signifies that this process has been completed.

At the same time, the DOC denied completing any follow-up, review or analysis, related to the above-noted incident; and was unable to locate any documentation to demonstrate that the review or analysis had been completed by a designate. There was no signature found on the bottom of the internal medication incident report form.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and, that all medication incidents and adverse drug reactions are reviewed and analyzed.

Issued on this 11th day of June, 2018

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

Original report signed by the inspector.

Ontario

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

Ministére 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) :	AMANDA NIXON (148), GILLIAN CHAMBERLIN (593), MICHELLE EDWARDS (655)
Inspection No. / No de l'inspection :	2018_617148_0009
Log No. / No de registre :	005324-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	May 23, 2018
Licensee / Titulaire de permis :	The Glebe Centre Incorporated 950 Bank Street, OTTAWA, ON, K1S-5G6
LTC Home / Foyer de SLD :	Glebe Centre 950 Bank Street, OTTAWA, ON, K1S-5G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lawrence Grant

To The Glebe Centre Incorporated, 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 O.Reg.79/10, s. 8 (1) (b).

Specifically, the licensee shall ensure that the following written policies and protocols developed for the medication management system under s. 114 (2), s. 123, and s. 136 (2) 2, of Ontario Regulation 79/10 are complied with:

- "Drug Destruction and Disposal" (#8-01, last revised in 2011); and,
- "Drug Storage - Contingency/Emergency Supply" (#6-02, last reviewed in July, 2008).

In order to ensure compliance with the above-noted policies, the licensee shall develop and implement monitoring and remedial processes:

(a) At a minimum, adherence to the policies by nursing staff will be measured on a weekly basis on all units for a period of four consecutive weeks.
(b) The licensee shall ensure that corrective action is taken if deviations are identified; and,
(c) A written record is kept of everything required under (a) and (b).

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or 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 plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with Ontario Regulation (O. Reg) 79/10, s. 136 (2) 2, the licensee's drug destruction and disposal policy must provide for the following:

That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Specifically, the licensee failed to ensure that the licensee's policy titled "Drug Destruction and Disposal" (8-01), revised in 2011, was complied with.

According to the policy titled "Drug Destruction and Disposal" (8-01), a surplus of prescribed drugs (those remaining in containers labeled with the name of a resident) can occur when the drug has been discontinued by the Attending Physician. In the policy, it is indicated that surplus drugs are rendered unusable on-site. According to the same policy, narcotics or other controlled substances that are to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.

Over the course of the inspection, registered nursing staff (RPN #127, RPN#126, RPN #125) described the processes in place related to the disposal of controlled substances. According to nursing staff, two staff members are required to, together, remove a resident's supply of narcotic or other controlled substance from the residents' supplies in the medication cart, and place it in a separate storage bin when the order for that narcotic or controlled substance has been discontinued.

i. A Critical Incident Report (CIR) was submitted to the Director under the Long-term Care Home's Act, 2007, related to a missing or unaccounted for controlled substance. According to the CIR, it was discovered by a member of the registered nursing staff on a specified date that a specific quantity of a specified controlled substance was missing. The controlled substance was ordered for resident # 045 and subsequently discontinued, after which time the staff member who discovered the incident identified a discrepancy in the documentation such that the medication was not identified on the count sheet as being discontinued.

Inspector #655 reviewed the health care record belonging to resident #045. According to the physician's orders, resident #045 was to receive a specified dose of the above-noted controlled substance at a specified frequency when needed. According to the order-history, the order was started on a specified date; and was discontinued five days later - approximately one week before the resident's supply of the controlled substance was found to be missing. According to the CIR, RPN #126 was one of two nurses whose signature was on the related Count sheet.

During an interview, RPN #126 recalled an incident in which an unspecified quantity of a specific controlled substance went missing in a specified month on resident # 045's home area. RPN #126 recalled that at that time, the controlled substance which had belonged to a specific resident had been discontinued. RPN #126 recalled counting that resident's supply of the controlled substance, and leaving it in the cart, even after the drug had been discontinued from the resident's drug regime. During the interview, RPN #126 indicated to Inspector #655 that the resident's supply of the specified controlled substance remained in the medication cart for an unspecified period of time after it was discontinued because it was difficult to find the time required to allow for two registered nursing staff members to dispose of the drug together.

During the inspection, Inspector #655 was provided with a copy of the investigation notes related to the above-described incident by the DOC. The investigation file included the documents titled "Surplus Prescribed Drugs" and "Narcotic/Controlled Substances Surplus Drugs". According to the DOC, a record of all destroyed drugs was expected to be maintained by documenting each destroyed drug on one of the above-noted forms. Inspector #655 reviewed both forms, and found no documentation that was indicative that the supply of the controlled substance that was previously prescribed for resident #045 had been destroyed. According to the DOC, the specified quantity of the controlled substance was never accounted for.

ii. A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

During the inspection, Inspector #655 reviewed the licensee's internal

investigation notes related to the above-noted incident. As a result of the internal investigation, numerous discrepancies in RN #128's documentation and practices were identified over a seven month period. According to the internal investigation notes, RN #128 was removing controlled substances from numerous residents' supplies. One such resident was resident #049.

Inspector #655 reviewed the health care record belonging to resident #049. According to the physician's order- history, resident #049 was prescribed a specified controlled substance on a specified date. According to the order-history, this order was discontinued on a specified date, and subsequently re-ordered approximately three months later. There was no order in place for resident #049 related to the use of the controlled substance during that three month period.

As part of the internal investigation file, Inspector #655 was provided with copies of the Narcotic and Controlled Drug Administration Record for resident #049. The Narcotic and Controlled Drug Administration Record for resident #049, as indicated on the form, was for the same controlled substance that had been discontinued, as described above.

According to the documentation on the Narcotic and Controlled Drug Administration Record for resident #049, doses of the controlled substance were administered on thirteen separate occasions over a period of eight days, although there were no orders for the controlled substance for resident #049 during that time.

In four of the thirteen instances, there is a written notation indicating that the controlled substance was removed from resident #049's supply to be given to resident #051. According to the licensee's internal investigation notes, there was no indication in the resident's eMAR that the controlled substance had actually been given as indicated on the resident's Narcotic and Controlled Drug Administration Record.

Inspector #655 also reviewed the documentation on a Ward Drug Count sheet (which also included counts of controlled substances), for resident #049's resident home area for a specified period. The Narcotic Ward Drug Count sheets included a count for the above-described controlled substance belonging to resident #049, although it had been discontinued.

During an interview, the DOC indicated that resident #049's supply of the specified controlled substance was retained after it was discontinued on a specified date.

The licensee failed to ensure that the licensee's policy titled "Drug Destruction and Disposal" (8-01), revised in 2011, was complied with.

1. In accordance with O. Reg. 79/10, s. 123 (b), every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply.

Specifically, the licensee failed to ensure that the policy titled "Drug Storage" "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008, provided to Inspector #655 by the DOC, was complied with.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

i. According to the policy titled "Drug Storage", "Contingency/Emergency Supply" (#6-02), where a narcotic is used from the emergency/contingency supply, only one vial or dose is to be signed out at a time.

Inspector #655 reviewed the licensee's internal investigation notes related to the above-described incident. According to the investigation notes, RN #128 removed more than one vial of the narcotic, hydromorphone (injectable formula), at one time from emergency/contingency supplies in the home on four separate occasions within a three month period:

- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Emergency/Contingency Supply located on Lindenwood,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Emergency/Contingency Supply located on Woodlawn,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable

from the Emergency/Contingency Supply located on Lindenwood; and,
- On a specified date, RN #128 removed 3 vials of hydromorphone injectable from the Woodland Emergency/Contingency Supply.

According to the documentation, four vials that were taken from the above-noted emergency supplies during a specified month were to be used for resident #047. Inspector #655 reviewed the health care record belonging to resident #047 and found there was, at no time in the specified month, an order for hydromorphine injectable for resident #047.

During an interview, RPN #125 recalled two incidents which occurred in a specified month where a member of the registered nursing staff had removed two or three hydromorphone injectables from one of the emergency supply stocks at one time. RPN #125 indicated to Inspector #655 that there had been no restrictions in place with regards to the amount of a narcotic that could be removed from an emergency supply stock at one time, noting that if a resident is to receive a narcotic every hour, a staff member may choose to remove several doses or vials from the emergency stock at one time.

During an interview, the DOC indicated to Inspector #655 that the policy titled "Contingency/Emergency Supply" (#6-02), last reviewed in July, 2008, was in place at the time of the above-described incidents; and that staff were expected to remove only one vial or dose of a narcotic, such as hydromorphone, from the emergency supply at one time.

ii. In the same policy "Drug Storage", "Contingency/Emergency Supply" (#6-02), designated storage locations for the emergency supply of the narcotic, hydromorphone, are identified. According to the policy, hydromorphone is to be stored in emergency supply stocks located on Glebewood and Queenswood units. The other emergency supply storage locations (Lindenwood and Woodlawn) were not designated for the storage of hydromorphone.

Inspector #655 reviewed the licensee's internal investigation notes related to the critical incident, as described in part (i) of the finding.

According to the investigation notes, RN #128 removed a total of 9 hydromorphone injectables (vials) from emergency supply stocks located in the undesignated storage areas of Lindenwood and Woodlawn over a three month period:

- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Lindenwood emergency supply stock,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Woodlawn emergency supply stock,
- On a specified date, RN #128 removed 2 vials of hydromorphone injectable from the Lindenwood emergency supply stock; and,
- On a specified date, RN #128 removed 3 vials of hydromorphone injectable from the Woodland emergency supply stock.

During an interview, the nurse auditor for the pharmacy service provider indicated to Inspector #655 that the narcotic, hydromorphone, had always been stored in all of the emergency supply stock locations (a total of five locations) in the home up until a specified date, at which time it was decided that the narcotic would only be stored in two designated emergency supply stock areas in the home. The nurse auditor indicted to Inspector #655 that they had been working in this role for two years.

During an interview, the DOC indicated to Inspector #655 that prior to the investigation into the CI they had not been aware that hydromorphone was being stored in the undesignated areas, emergency supply stock locations located on Woodlawn and Lindenwood.

Over the course of the inspection, the DOC indicated to Inspector #655 that over the six month period in which the misappropriation of controlled substances had occurred, there had been no mechanisms in place whereby compliance with the licensee's medication management system policies could be evaluated.

The licensee failed to ensure that the policies, "Drug Destruction and Disposal" (#8-01) and "Drug Storage – "Contingency/Emergency Supply" (#6-02), were complied with.
(Log 023240-17)
(655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2018

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (2) The licensee shall 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. O. Reg. 79/10, s. 114 (2).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 114 (2).

Specifically, the licensee shall ensure that existing written policies and protocols are revised; or, new policies and protocols are developed for the medication management system to ensure: the accurate administration of contingency or emergency supply drugs; and, the accurate destruction and disposal of wasted drugs.

The licensee shall ensure that the written policies and protocols for the medication management system are revised or developed in accordance with all applicable requirements provided for in the regulations; and that, at a minimum, they provide for:

a) Clearly defined parameters for accessing drugs stored in contingency or emergency supplies; and a process for ensuring that the drug is used in accordance with the intent identified at the time of removal,
a) A clear process for obtaining a drug when it is required for a resident when that resident does not have an assigned supply, or the assigned supply is depleted; and,
b) Clearly defined practice expectations with regards to the wasting of a drug, including the role of a witness and requirements for obtaining and providing a witness signature.

Grounds / Motifs :

1. he licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration

medications taken from alternate drug supplies and the accurate destruction and disposal of drugs.

A CIR was submitted to the Director under the Long-term Care Homes Act, 2007, related to missing or unaccounted for controlled substances. According to the CIR, irregularities in the medication handling practices and possible misappropriation of controlled drugs by a specific registered staff member (RN #128) was suspected.

During the inspection, Inspector #655 was provided with a copy of a Health Canada document titled "Loss or Theft Report Form for Controlled Substances and Precursors". On that form, under "List of controlled substances - precursors lost or stolen" the following items are identified as being lost or stolen:
- 85 vials of midazolam injectables (5mg/ml), and an additional 19 vials of midazolam injectables allegedly broken or destroyed,
- 28 vials of hydromorphone injectables (2mg/ml); and,
- 8 hydromorphone (1 mg) tablets.

In the CIR, it is further indicated that RPN #127 admitted that they had signed as a witness for 10 broken vials of of a specified controlled substance when asked to do so by RN #128 on a specified date.

According to the CIR, RPN #127 agreed to sign as a witness without having seen the broken vials; and when the event happened three days earlier.

During an interview, RPN #127 confirmed that they had signed as a witness without having observed the waste, noting that RN#128 had initially wasted the medication without obtaining a witness.

In addition, the licensee's internal investigation into the incident involved a review of seven residents' Narcotic and Controlled Substances Administration Records. As a result, discrepancies were identified including numerous transfers of resident-assigned controlled substances, and unwitnessed wasting of medications.

Inspector #655 reviewed the Narcotic and Controlled Drug Administration Records (the record) belonging to one of the seven residents', resident #048. The medication identified on each of the records for resident #048 was a specified controlled substance. The directions, according to the record were to

administer the drug at a specified frequency when needed. According to the documentation on resident #048's record, a dose of the controlled substance was removed from resident #048's medication supply a total of 53 times over a six week period.

On the same record for resident #048, there is a written notation on 22 of the 53 occasions which indicates that the dose was removed from resident #048's medication supply to be administered to a co-resident. Most frequently, the co-resident is identified as being resident #051.
According to the licensee's internal investigation notes, which included a copy of resident #051's MAR, the documentation in resident #051's MAR was not consistent with the documentation on resident #048's Narcotic and Controlled Substance Administration Record in that there was no indication on resident #051's MAR that the resident had received the medication that was removed from resident #048's medication supply on the following dates: June 7, 12, 14, 16, 19, 22, 25, and 29, 2017; and, July 3, 4, 5, 6, 8, and 9, 2017.

On the same record for resident #048, a written notation in four instances is indicative that a vial of the controlled substance was wasted (broken or destroyed); though there was no witness signature found on the record.

During an interview, RPN#125 recalled several instances in which a specific nurse had removed controlled substances from a resident or emergency/contingency supply for the purpose of administering the medication to a resident who resided in another resident home area. According to RPN #125 there had been no policy or protocol in place to ensure that the medication was administered to the co-resident on another resident home area, as was indicated by the nurse at the time.

Over the course of the inspection, the DOC indicated to Inspector #655 that signing for a wasted medication without seeing the waste, the practice of wasting a controlled substance without a witness, and the practice of transferring resident-assigned controlled substances is not consistent with practice expectations. According to the DOC, residents who regularly require a specified medication, would be expected to have an order and thus their own supply available; and in other specific circumstances, staff would be expected to access the emergency/contingency medication supplies as opposed to other resident-assigned medications. At the same time, the DOC indicated to Inspector #655 that there had been no written policy or protocol in place which outlined the

above-noted expectations related to obtaining a witness-signature for wasted medications; or with regards to the transferring of resident assigned medications.

The licensee failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate administration of medications taken from supplies that did not belong to the receiving resident; and the accurate destruction and disposal of wasted drugs.
(655)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 16, 2018

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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 23rd day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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