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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 19, 2019	2019_778563_0006	029565-18, 000870-19, 000963-19	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

MELANIE NORTHEY (563)

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 30 and 31 and February 1 and 5, 2019

The following intakes were completed during the course of this inspection:

Critical Incident (CI):
Log #000870-19 / CI #2636-000004-19
Log #000963-19 / CI #2636-000005-19

Follow Up:
Log #029565-18 / Compliance Order #006 with a compliance due date of November 30, 2018

During the course of the inspection, the inspector(s) spoke with the Caressant Care Regional Director, the Executive Director, the Director of Operations, the Director of Nursing, the Pharmacist Manager, the Consultant Pharmacist, the Resident Care Coordinator, two Maintenance staff members, Registered Practical Nurses, and Registered Nurses.

The inspector also observed drug storage areas and the drug destruction of controlled and non-controlled medications. Relevant policies and procedures, investigation notes, clinical records and reports for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Medication

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

Ontario Regulation 79/10 s. 114 (2) states, "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."

Ontario Regulation 79/10 s. 136 (1) states, “Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of" drugs.

Ontario Regulation 79/10 s. 136 (2) states, “The drug destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. 2. 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.”

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

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long

Term Care and documented a "Controlled Substance missing/unaccounted" for multiple residents.

The home's investigation notes included an interview with a Registered Nurse (RN) and the RN verified that they did not follow the home's policy related to drug destruction and disposal. The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017 documented that monitored medications, including narcotics and controlled substances, were to be retained in the double locked wooden box, in the locked medication room, separate from those medications available for administration to a resident. "Two nurses will be accountable to complete and double sign medication onto Drug Destruction and Disposal form and place medication into a locked monitored drug storage (i.e. wooden box) until drug destruction takes place." "On the Individual Monitored Medication Record: record the quantity for destruction, initials, date and reason for destruction at the bottom of the form." The Director of Operations verified that the RN did not follow the drug destruction and disposal policy for controlled or non-controlled medications.

Inspector #563 and the Resident Care Coordinator (RCC) made observations of the following medication storage areas:
a) The "Level 1", medication room A142, was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. The lid was clear taped to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, inhalers, medications in foil packaging, eye drops and resident medication strip packages. The RCC stated that the lids were removable and there was no water added to the container. The RCC stated that when the container reaches about half full they would give it to maintenance staff and with the Director of Care (DOC) it would then be taken to the medication storage room downstairs where the government stock was stored. Only the registered nursing staff have access to the room. The DOC would then add water to the container and the container would stay there until Stericycle picked it up. The RCC verified that the non-controlled medications were not denatured when the containers were stored in the medication rooms.

b) The "Level 2", medication room A242, was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. The lid was secured to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, resident medication strip packages, prescription creams and full Haloperidol ampules inside. The

RCC verified that the medications were not denatured.

c) The "Medication Storage" room in B section for North, East and South wing was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. This cabinet had a latch and pad lock in place that was not in the locked position and was hanging from the latch. The lid was secured to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, inhalers and resident medication strip packs. The RCC verified that the medications were not denatured.

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017 documented that "all medications which become surplus are destroyed and disposed of according to applicable legislation." "Medications are considered destroyed when they are altered to such an extent that their consumption is rendered impossible or improbable." The home was to store non-narcotic and non-controlled medications "for destruction/disposal in a locked area in the medication room, separate from medications for administration to a resident, until container is full. These medications should not be available to reuse."

The Consultant Pharmacist (CP) stated that the home would ensure safe storage of non-controlled medications for destruction using the Stericycle containers stored in each of the medication rooms in a locked cupboard. The CP stated that the DOC or delegate were to add water to the containers and store them in the basement storage area when the containers were almost full. The CP stated that the destruction of ampules included breaking the full ampule and pouring the liquid in a Ziploc baggy with soapy water as recommended and the glass ampule discarded in the sharps container. For the destruction of individual resident medication strip packs, the medications need to be removed by opening the package and removing the medication for the destruction container. The CP also stated that those medications packaged in foil or in pharmacy bottles, they too were to be opened and the medication removed. The CP stated that the Stericycle containers were audited twice a year.

In the "Level 1" medication room A142 , the RN verified there were loose pills, inhalers, unopened resident strip packs and medications still in their original packaging observed in the Stericycle container kept under the sink. The RN stated it was their understanding that pharmacy would collect the containers during their regular visits and that the registered nursing staff have never added water the containers while stored in the medication rooms. The RN also verified that the medications could be dumped out of the

container in their original form and consumed.

On B side, the RN also stated that pharmacy picked up the Stericycle containers; that discontinued or refused creams, pills, or puffers were put in the Stericycle container and that water was added, but not by the nurses.

The Director of Operations was shown the pictures taken of the Stericycle containers and acknowledged that the medications were not rendered impossible or improbable for use. The Director of Operations and Inspector #563 went to the Maintenance Room. Maintenance staff clarified that maintenance only picked up the sharps containers and stored them in the maintenance room, but that the Stericycle containers were picked up by maintenance in the presence of the Charge Nurse and brought to the basement storage area used for medications. The maintenance staff verified that only registered nursing staff have access to the basement medication storage room.

Inspector #563 and the Director of Operations made observations of the following medication storage areas:
a) The "Level 1", medication room A142, was observed with the RN present. The Director of Operations verified that medications in the Stericycle containers were not altered or denatured to such an extent that its consumption was rendered impossible or improbable and that the medication could be poured from the container and used.

b) The basement medication storage area was observed with the RCC providing access to the locked room. There were seven Stericycle containers present, four belonging to the Long Term Care Home and the other three were labelled for retirement. The medications in three of four containers had medications that were accessible, lids were easily removed by Inspector #563 and the medications were not considered destroyed since the medications were not altered or denatured to such an extent that its consumption was rendered impossible or improbable. This was verified by the Director of Operations. Inspector #563 was able to remove several full unaltered resident medication strip packs from a full container marked "PILLS ONLY – no wrappers, - no creams, -no nonsense".

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017 documented:
- Tablets or capsules in vials/bottles: "are to be poured carefully into the Drug Destruction Container from their original bottles",
- Tablets or capsules in pouches: "strips are cut open up the side using scissors",

- Tablets or capsules in cards: "are removed from their original packaging and placed into the Drug Destruction Container",
- Liquid medications: "add liquid detergent to the bottle and mark the bottle with a large X using a black marker/pen and apply "External" auxiliary sticker. Add the bottle to the Drug Destruction Container",
- Patches: "are removed from their boxes and cut in half and placed into the Drug Destruction Container", and
- Ampoules: "are broken in half and the contents are poured into the Drug Destruction Container".

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017, documented "Once the Drug Destruction Container is full, medications are destroyed with the addition of enough soapy water which renders the reuse of the contents impossible or improbable. The container is immediately sealed and set aside in a secure area for removal by the designated waste disposal company." The Director of Operations verified that non-controlled medications were not destroyed according to the procedures outlined in the policy and therefore the policy was not complied with. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 117. Medical directives and orders — drugs
Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Findings/Faits saillants :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs.

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care and documented a medication incident involving a resident. The resident returned to Caressant Care Woodstock (CCW) from hospital. Medication reconciliation was completed by the Registered Practical Nurse (RPN) with the consolidated orders from the nursing home and a list of medications that were faxed from the hospital. Medication reconciliation was then completed with the Physician via telephone and the documents were faxed to Medical Pharmacies. However, the RPN made an transcription error, documenting medications that belonged to another resident. When medication reconciliation was completed, the Physician had approved medications that belonged to the other resident.

The Medical Pharmacies Best Possible Medication History (BPMH) Reconciliation / Admission Orders documented multiple medications were checked as "continue" by the Physician for the resident. The medications were ordered and documented as part of a "Medication List" from hospital for a retirement home resident.

The electronic Medication Administration Record (eMAR) documented that the resident was administered medications that were not previously ordered prior to discharge to hospital and that were originally ordered for a resident who lived in retirement at CCW.

The resident experienced an adverse drug reaction with a documented medication incident severity/outcome of "E" with increasing degree of harm.

The clinical record in Point Click Care (PCC) for the resident was reviewed and there was no documented specific diagnoses to support the administration of specific medications. The resident's vital signs documented a significant change.

The RPN stated it was discovered that there were medications reconciled for the resident that belonged to a retirement resident. The RPN stated the process for medication reconciliation included the review of the “Consolidated Orders (Chart)” in PCC against the medication list sent from the hospital and were to be documented on the BPMH form and faxed to the doctor and pharmacy. There were two different names on the forms

faxed from the hospital and this was not checked at the time of reconciliation.

The Medical Pharmacies Medication Reconciliation Policy 7-2 last revised February 2017 stated, "Medication reconciliation is a multidisciplinary process to identify and consolidate the Best Possible Medication History (BPMH) for a resident upon transfer of care (i.e. admission, readmisson or discharge) to ensure accuracy and continuity or medication orders and reduce potential adverse events or harm." "This process involves obtaining accurate information regarding medication history from a variety of sources and reconciling the information gathered to determine an accurate list of current medication orders as well as information regarding previous medication use and reasons they have been prescribed or discontinued." "Discrepancies (intentional or unintentional) are identified to avoid unintentional changes in therapy."

The Pharmacist Manager verified that the Medical Pharmacies Medication Reconciliation Policy 7-2 was the current policy in use in the home. The Pharmacy Manager identified that the name of the resident did not appear on all of the 11 pages faxed from the home. Two pages identified the medication list for a resident on the retirement side of Caressant Care Woodstock. The identification of the resident was missed by the home and pharmacy. The Pharmacy Manager verified that the resident did not have specific diagnoses to support the administration of specific medications.

The Resident Care Coordinator (RCC) verified that the treatment plan was not individualized to the resident's condition and needs. Reconciliation Policy 7-2 stated, “Discuss/identify the history of medical conditions related to medications recently started or stopped and document why”. The RCC verified that this did not occur for the resident.

The licensee failed to ensure that no order for the administration of a drug to the resident was used unless it was individualized to the resident's condition and needs. [s. 117. (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Written Notification (WN) and a Compliance Order (CO) was issued during the Resident Quality Inspection. Specifically the licensee was to ensure that drugs were administered to two specific residents and any other resident of the home in accordance with the directions for use specified by the prescriber. The home was also to provide to the Director of Care (DOC) as well as all Registered Practical Nurses (RPNs) and Registered Nurses (RNs) who administer medication training on the appropriate administration of "as needed" insulin in accordance with the directions for use specified by the prescriber and training on the home's policies and procedures, including the Medical Directives, related to capillary blood sugar checks (glucometer). The home was then to ensure that the plan of care related to capillary blood checks (glucometer) for a specific resident and any other resident with an as needed insulin order, was reviewed and revised to meet the needs of that resident. The home was compliant with the CO, however there was continued non-compliance with s. 131(2).

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care and documented a "Controlled Substance missing/unaccounted" for multiple residents.

The home's investigation notes included an interview with the RN who acknowledged that they signed that a medication was administered, but did not actually administer it to the resident. The physician's order documented in PCC stated the resident was prescribed a controlled substance twice daily.

The Medical Pharmacy "Rx for Drug / Doctor Groups Report" documented those residents who were prescribed a specific oral controlled substance. This report was compared to the electronic Medication Administration Records (eMAR) for four residents. The RN had opportunity to take regularly scheduled oral controlled substances for the

four residents who were ordered the medication routinely.

The Director of Operations stated that the RN admitted to withholding the resident's medication that was ordered twice daily. When the eMAR was shown to the RN, the RN acknowledged that they signed the medication as administered, but there were times that the resident did not get it. The Director of Operations verified that resident was not administered their medication in accordance with the directions for use.

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

Inspector #563 and the Resident Care Coordinator (RCC) made observations of medication storage areas. The "Level 1" medication cart was observed and the Registered Nurse (RN) and Registered Practical Nurse (RPN) were present when the Inspector asked to see the controlled substance storage within the medication cart. When the bottom drawer was opened, the narcotic and controlled substance storage bin was located to the right side of the drawer and was not securely closed and locked at the time of the observation and was easily opened without a key. The RCC reminded staff to ensure the lid was secure and closed when not in use.

The "Level 2" medication cart was observed with the RPN present and just closed the bottom drawer of the medication cart when we approached. The narcotic storage and controlled substance storage bin lid was not securely closed and locked at the time of the observation and was easily opened without a key. The RCC verified that the controlled substances were to be stored in a separate locked area within the locked medication cart and that the vendor would be called to fix the problem.

The Executive Director (ED) stated they were aware that two of three medication carts were observed with the narcotic and controlled substance storage bin lid not securely closed and locked.

The Medication Cart and Storage Maintenance Policy 3-5 last revised February 2017 stated that narcotic and controlled medications were to be stored in the locked narcotic bin in the medication cart.

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart on Level 1 and Level 2. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

Issued on this 20th day of February, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2019_778563_0006
Log No. / No de registre :	029565-18, 000870-19, 000963-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Feb 19, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Swamy Bidarekere

To Caressant-Care Nursing and Retirement Homes Limited, 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 must:
a) Ensure that the home's drug destruction and disposal policy is complied with related to best practice guidelines for non-controlled and controlled medications.

b) Ensure that drugs to be destroyed are altered or denatured to such an extent that its consumption is rendered impossible or improbable.
c) Ensure that all home leadership team members, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) are re-educated related to the drug destruction and disposal policy. The home must keep a documented record of the education provided and attendance.

Grounds / Motifs :

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

Ontario Regulation 79/10 s. 114 (2) states, "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."

Ontario Regulation 79/10 s. 136 (1) states, "Every licensee of a long-term care

home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of" drugs.

Ontario Regulation 79/10 s. 136 (2) states, “The drug destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. 2. 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.”

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

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care and documented a "Controlled Substance missing/unaccounted" for multiple residents.

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Inspector #563 and the Resident Care Coordinator (RCC) made observations of

the following medication storage areas:
a) The "Level 1", medication room A142, was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. The lid was clear taped to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, inhalers, medications in foil packaging, eye drops and resident medication strip packages. The RCC stated that the lids were removable and there was no water added to the container. The RCC stated that when the container reaches about half full they would give it to maintenance staff and with the Director of Care (DOC) it would then be taken to the medication storage room downstairs where the government stock was stored. Only the registered nursing staff have access to the room. The DOC would then add water to the container and the container would stay there until Stericycle picked it up. The RCC verified that the non-controlled medications were not denatured when the containers were stored in the medication rooms.

b) The "Level 2", medication room A242, was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. The lid was secured to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, resident medication strip packages, prescription creams and full Haloperidol ampules inside. The RCC verified that the medications were not denatured.

c) The "Medication Storage" room in B section for North, East and South wing was observed to be locked. A Stericycle container was noted in an unlocked cabinet under the sink. This cabinet had a latch and pad lock in place that was not in the locked position and was hanging from the latch. The lid was secured to the container and there was access through an opening in the lid that had a screw top cover. Inside the container there were loose non-controlled resident medications, inhalers and resident medication strip packs. The RCC verified that the medications were not denatured.

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consumption is rendered impossible or improbable." The home was to store non-narcotic and non-controlled medications "for destruction/disposal in a locked area in the medication room, separate from medications for administration to a resident, until container is full. These medications should not be available to reuse."

The Consultant Pharmacist (CP) stated that the home would ensure safe storage of non-controlled medications for destruction using the Stericycle containers stored in each of the medication rooms in a locked cupboard. The CP stated that the DOC or delegate were to add water to the containers and store them in the basement storage area when the containers were almost full. The CP stated that the destruction of ampules included breaking the full ampule and pouring the liquid in a Ziploc baggy with soapy water as recommended and the glass ampule discarded in the sharps container. For the destruction of individual resident medication strip packs, the medications need to be removed by opening the package and removing the medication for the destruction container. The CP also stated that those medications packaged in foil or in pharmacy bottles, they too were to be opened and the medication removed. The CP stated that the Stericycle containers were audited twice a year.

In the "Level 1" medication room A142 , the RN verified there were loose pills, inhalers, unopened resident strip packs and medications still in their original packaging observed in the Stericycle container kept under the sink. The RN stated it was their understanding that pharmacy would collect the containers during their regular visits and that the registered nursing staff have never added water the containers while stored in the medication rooms. The RN also verified that the medications could be dumped out of the container in their original form and consumed.

On B side, the RN also stated that pharmacy picked up the Stericycle containers; that discontinued or refused creams, pills, or puffers were put in the Stericycle container and that water was added, but not by the nurses.

The Director of Operations was shown the pictures taken of the Stericycle containers and acknowledged that the medications were not rendered impossible or improbable for use. The Director of Operations and Inspector #563 went to the Maintenance Room. Maintenance staff clarified that maintenance

only picked up the sharps containers and stored them in the maintenance room, but that the Stericycle containers were picked up by maintenance in the presence of the Charge Nurse and brought to the basement storage area used for medications. The maintenance staff verified that only registered nursing staff have access to the basement medication storage room.

Inspector #563 and the Director of Operations made observations of the following medication storage areas:
a) The "Level 1", medication room A142, was observed with the RN present. The Director of Operations verified that medications in the Stericycle containers were not altered or denatured to such an extent that its consumption was rendered impossible or improbable and that the medication could be poured from the container and used.

b) The basement medication storage area was observed with the RCC providing access to the locked room. There were seven Stericycle containers present, four belonging to the Long Term Care Home and the other three were labelled for retirement. The medications in three of four containers had medications that were accessible, lids were easily removed by Inspector #563 and the medications were not considered destroyed since the medications were not altered or denatured to such an extent that its consumption was rendered impossible or improbable. This was verified by the Director of Operations. Inspector #563 was able to remove several full unaltered resident medication strip packs from a full container marked "PILLS ONLY – no wrappers, - no creams, -no nonsense".

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017 documented:
- Tablets or capsules in vials/bottles: "are to be poured carefully into the Drug Destruction Container from their original bottles",
- Tablets or capsules in pouches: "strips are cut open up the side using scissors",
- Tablets or capsules in cards: "are removed from their original packaging and placed into the Drug Destruction Container",
- Liquid medications: "add liquid detergent to the bottle and mark the bottle with a large X using a black marker/pen and apply "External" auxiliary sticker. Add the bottle to the Drug Destruction Container",

- Patches: "are removed from their boxes and cut in half and placed into the Drug Destruction Container", and
- Ampoules: "are broken in half and the contents are poured into the Drug Destruction Container".

The Medical Pharmacies Drug Destruction and Disposal Policy 5-4 last revised February 2017, documented "Once the Drug Destruction Container is full, medications are destroyed with the addition of enough soapy water which renders the reuse of the contents impossible or improbable. The container is immediately sealed and set aside in a secure area for removal by the designated waste disposal company." The Director of Operations verified that non-controlled medications were not destroyed according to the procedures outlined in the policy and therefore the policy was not complied with.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home had a level 5 history as the home had multiple non-compliance with at least one related order to the current area of concern with this section of the LTCHA and included:
- Written Notification (WN) and Compliance Order (CO) issued October 23, 2018 (2018_722630_0019);
- WN and CO issued July 16, 2018 (2018_508137_0017). The CO was closed with link October 23, 2018 (2018_722630_0019);
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN, CO and Director's Referral issued August 24, 2017 (2017_605213_0015). The CO was compiled October 5, 2017;
- WN and CO issued May 24, 2017 (2016_229213_0039);
- WN and VPC issued January 24, 2017 (2016_303563_0042);
- WN issued August 15, 2017 (2016_229213_0035); and
- WN issued October 16, 2016 (2016_326569_0021).

(563)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

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. 117. Every licensee of a long-term care home shall ensure that,
(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and
(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 117 (b).

Specifically the licensee must:
a) Ensure that the home's Medication Reconciliation policy is complied with.
b) Ensure the resident and any other resident upon readmission to the home has the Medical Pharmacies Best Possible Medication History (BPMH) Reconciliation / Admission Orders completed accurately.
c) Ensure that all nursing leadership team members, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) working in the home are re-educated on the Medication Reconciliation policy. The home must keep a documented record of the education provided and attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that no medical directive or order for the administration of a drug to a resident was used unless it was individualized to the resident's condition and needs.

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care and documented a medication incident involving a resident. The resident returned to Caressant Care Woodstock (CCW) from hospital. Medication reconciliation was completed by the Registered Practical Nurse

(RPN) with the consolidated orders from the nursing home and a list of medications that were faxed from the hospital. Medication reconciliation was then completed with the Physician via telephone and the documents were faxed to Medical Pharmacies. However, the RPN made an transcription error, documenting medications that belonged to another resident. When medication reconciliation was completed, the Physician had approved medications that belonged to the other resident.

The Medical Pharmacies Best Possible Medication History (BPMH) Reconciliation / Admission Orders documented multiple medications were checked as "continue" by the Physician for the resident. The medications were ordered and documented as part of a "Medication List" from hospital for a retirement home resident.

The electronic Medication Administration Record (eMAR) documented that the resident was administered medications that were not previously ordered prior to discharge to hospital and that were originally ordered for a resident who lived in retirement at CCW.

The resident experienced an adverse drug reaction with a documented medication incident severity/outcome of "E" with increasing degree of harm.

The clinical record in Point Click Care (PCC) for the resident was reviewed and there was no documented specific diagnoses to support the administration of specific medications. The resident's vital signs documented a significant change.

The RPN stated it was discovered that there were medications reconciled for the resident that belonged to a retirement resident. The RPN stated the process for medication reconciliation included the review of the “Consolidated Orders (Chart)” in PCC against the medication list sent from the hospital and were to be documented on the BPMH form and faxed to the doctor and pharmacy. There were two different names on the forms faxed from the hospital and this was not checked at the time of reconciliation.

The Medical Pharmacies Medication Reconciliation Policy 7-2 last revised February 2017 stated, "Medication reconciliation is a multidisciplinary process to identify and consolidate the Best Possible Medication History (BPMH) for a

resident upon transfer of care (i.e. admission, readmisson or discharge) to ensure accuracy and continuity or medication orders and reduce potential adverse events or harm." "This process involves obtaining accurate information regarding medication history from a variety of sources and reconciling the information gathered to determine an accurate list of current medication orders as well as information regarding previous medication use and reasons they have been prescribed or discontinued." "Discrepancies (intentional or unintentional) are identified to avoid unintentional changes in therapy."

The Pharmacist Manager verified that the Medical Pharmacies Medication Reconciliation Policy 7-2 was the current policy in use in the home. The Pharmacy Manager identified that the name of the resident did not appear on all of the 11 pages faxed from the home. Two pages identified the medication list for a resident on the retirement side of Caressant Care Woodstock. The identification of the resident was missed by the home and pharmacy. The Pharmacy Manager verified that the resident did not have specific diagnoses to support the administration of specific medications.

The Resident Care Coordinator (RCC) verified that the treatment plan was not individualized to the resident's condition and needs. Reconciliation Policy 7-2 stated, “Discuss/identify the history of medical conditions related to medications recently started or stopped and document why”. The RCC verified that this did not occur for the resident.

The licensee failed to ensure that no order for the administration of a drug to the resident was used unless it was individualized to the resident's condition and needs

The severity was determined to be a level 3 as there was actual harm/risk to this resident. The scope of this issue was isolated to this one resident during the course of this inspection. There was no compliance history of this legislation being issued in the home in the past three years. (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2019

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2018_722630_0019, CO #006;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 131 (2) .

Specifically the licensee must:
a) Ensure three residents and any other resident are administered a specific medication in accordance with the directions for use specified by the prescriber.
b) Ensure that all Registered Nurses and Registered Practical Nurses receive education on the process related to the administration of an injectable controlled substance according to the home's policy. The home must keep a documented record of the education provided and attendance.

Grounds / Motifs :

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

A Written Notification (WN) and a Compliance Order (CO) was issued during the Resident Quality Inspection. Specifically the licensee was to ensure that drugs were administered to two specific residents and any other resident of the home in accordance with the directions for use specified by the prescriber. The home was also to provide to the Director of Care (DOC) as well as all Registered Practical Nurses (RPNs) and Registered Nurses (RNs) who administer medication training on the appropriate administration of "as needed" insulin in accordance with the directions for use specified by the prescriber and training on the home's policies and procedures, including the Medical Directives, related to capillary blood sugar checks (glucometer). The home was then to ensure that the plan of care related to capillary blood checks (glucometer) for a specific

resident and any other resident with an as needed insulin order, was reviewed and revised to meet the needs of that resident. The home was compliant with the CO, however there was continued non-compliance with s. 131(2).

A Critical Incident (CI) System report was submitted to the Ministry of Health and Long Term Care and documented a "Controlled Substance missing/unaccounted" for multiple residents.

The home's investigation notes included an interview with the RN who acknowledged that they signed that a medication was administered, but did not actually administer it to the resident. The physician's order documented in PCC stated the resident was prescribed a controlled substance twice daily.

The Medical Pharmacy "Rx for Drug / Doctor Groups Report" documented those residents who were prescribed a specific oral controlled substance. This report was compared to the electronic Medication Administration Records (eMAR) for four residents. The RN had opportunity to take regularly scheduled oral controlled substances for the four residents who were ordered the medication routinely.

The Director of Operations stated that the RN admitted to withholding the resident's medication that was ordered twice daily. When the eMAR was shown to the RN, the RN acknowledged that they signed the medication as administered, but there were times that the resident did not get it. The Director of Operations verified that resident was not administered their medication in accordance with the directions for use.

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

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home had a level 5 history as the home had multiple non-compliance with at least one related order to the current area of concern with this section of the LTCHA and included:
- Written Notification (WN) and Compliance Order (CO) issued October 23, 2018 (2018_722630_0019);

- WN and CO served October 6, 2017 (2017_605213_0020). The CO was complied November 27, 2017.
- WN, CO and Director's Referral issued August 24, 2017 (2017_605213_0015). The CO was closed with link October 6, 2017 (2017_605213_0020);
- WN and CO issued June 29, 2017 (2017_605213_0008). The CO was closed with link August 23, 2017 (2017_605213_0015);
- WN issued May 24, 2017 (2016_229213_0039);
- WN and CO issued January 24, 2017 (2016_229213_0035) The CO was complied November 27, 2017.

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 19th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Melanie Northey

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