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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 3, 2019	2019_520622_0007	031599-18, 005202-19, 005358-19	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

The Palace
92 Centre Street ALEXANDRIA ON K0C 1A0

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

HEATH HEFFERNAN (622)

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): April 29, 30, 2019 and May 1, 2019.

The following Logs were completed during this inspection:

Log #031599-18/Critical Incident System report (CIS) #2642-000014-18 related to a fall incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status. Log #005202-19/CIS #2642-000003-19 and Log #005358-19/CIS #2642-000004-19 related to missing/unaccounted for controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing (DON), the Assistant Director of Care (ADOC)/RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and the residents.

Also during the course of the inspection, the inspector reviewed hard copy and electronic health records, critical incident system reports, the home's applicable investigation reports, medication incident reports, medication management and registered staff meeting minutes, the licensee's policies and procedures related to the falls prevention and management program, and the management of narcotic and controlled drugs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
2 WN(s)
1 VPC(s)
0 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 :

The licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with.

O. Reg. 79/10, s. 114 (2). stated that 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.
(3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practice.

On April 30, 2019 at 1237 hours, inspector #622 reviewed the licensee's Policy #RC-01-13 which was updated February 2017. The policy stated on Page 3 of 7 related to missing or tampered narcotics that the home will notify health regulatory, professional college or association and police as per jurisdictional legislation, requirements and directives.

Critical Incident System report (CIS) #2642-000003-19 dated a specified date and time stated that during shift change narcotic count, two registered nurses noted that resident #002's narcotic card was missing one half tablet of a narcotic medication for the following date's dose. The CIS report did not indicate that the police had been notified.

On April 30, 2019 at 1451 hours, inspector #622 reviewed the Medication Incident/Near Miss Report dated a specified date for resident #002. The report stated that there was a missing half tablet of a narcotic medication noted during the shift change narcotic count

between registered nurses (RN) #106 and RN #109. The Medication Incident/Near Miss Report did not state that the police had been notified.

On April 30, 2019 at 1108 hours, inspector #622 reviewed the home's Missing Narcotic Investigation documentation dated on a specified date for resident #002's missing half tablet of narcotic medication. The home's investigation documentation did not indicate that the police were notified.

On May 1, 2019 at 1105 hours, inspector #622 interviewed the Assistant Director of Care (ADOC) #102 who stated that they had completed the documentation on the home's investigation conclusion for the medication incident related to resident #002's missing narcotic medication on the specified date. ADOC #102 stated that the notation related to the police being aware was not documented for the incident related to resident #002 on the specified date. ADOC #102 further stated that they had not reported the incident related to resident #002's missing half tablet of narcotic medication on the specified date to the police.

On May 1, 2019 at 1155 hours, inspector #622 reviewed the home's medication incident reports for two specified months. A medication incident report for resident #004 dated a specified date and time, stated that RN #109 had noted during their shift change narcotic count that resident #004's narcotic card was missing a half tablet of the narcotic medication from slot #1. The medication incident report did not state that the police had been notified regarding resident #004's missing half tablet of narcotic medication.

During a telephone interview with inspector #622 on May 1, 2019 at 1030 hours, the Director of Nursing (DON) #101 stated that the licensee's policy related to missing narcotics and controlled drugs indicated that the Ministry of Health and Long-Term Care and the police would be notified if a narcotic or controlled drug was missing. The DON stated that they could not recall if they had notified the police for the incident on the specified date related to resident #002's missing half tablet of narcotic medication. The DON also stated that if they had reported the incident to the police, it would have been documented in the investigation notes. DON #101 further stated that they did not think the police were warranted for an incident with only one pill missing. During a separate telephone interview on May 1, 2019 at 1228 hours, DON #101 stated that the police were not notified of the missing narcotic incident for resident #004 on the specified date.

Therefore the licensee has failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with. [s. 8. (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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #2: 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 has failed to ensure that that the Director is informed of a missing or unaccounted for controlled substance in the home no later than one business day after the occurrence of the incident.

On May 1, 2019 at 1155 hours, inspector #622 reviewed the home's medication incident reports dated for a specified two month period. A medication incident dated for a specified date related to resident #004 indicated that during shift change, RN #109 observed that resident #004's medication card was missing a half tablet of a specified narcotic medication from slot #1. The home's medication incident report did not indicate that the Ministry of Health and Long-Term Care had been notified.

On May 1, 2019 at 1217 hours, inspector #622 reviewed the Ministry of Health and Long-Term Care Critical Incident System (CIS) reporting online and noted there were no CIS reports for missing narcotics and controlled substances for the home on the specified date.

During an interview with inspector #622 on May 1, 2019 at 1228 hours, Director of Nursing (DON) #101 stated that they had not notified the Ministry of Health and Long-Term Care regarding the missing half tablet of narcotic medication for resident #004 on the specified date. [s. 107. (3) 3.]

Issued on this 23rd day of May, 2019

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

Original report signed by the inspector.