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**

**Division des foyers de soins de longue durée**
**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 |
|---|---|---|---|
| Jun 19, 2018 | 2018_395613_0013 | 003870-18, 004716-18, 004910-18, 006432-18, 006572-18, 006629-18, 007043-18, 009636-18 | Critical Incident System |

**Licensee/Titulaire de permis**

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare York
333 York Street SUDBURY ON P3E 5J3

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

LISA MOORE (613), SYLVIE BYRNES (627)

## 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): May 17-18, 2018 and May 22-25, 2018.**

**A Follow Up Inspection #2018_395613_0011 and a Complaint Inspection #2018_395613_0012 were completed concurrently with this Critical Incident System Inspection. Please see the additional reports for further findings of non**

**compliance.**

**The following intakes were completed during this Critical Incident System Inspection:**

**Three Critical Incident (CIs) reports the home submitted to the Director regarding missing/unaccounted controlled substances;**

**Two CI reports the home submitted to the Director regarding resident to resident abuse;**

**One CI report the home submitted to the Director regarding improper/incompetent treatment;**

**One CI report the home submitted to the Director regarding a fall resulting in an injury;**

**One CI report the home submitted to the Director regarding an infection control enteric outbreak.**

**During the course of the inspection, the inspector(s) spoke with the Administrator (ADM), Director of Care (DOC), Assistant Directors of Care (ADOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members and residents.**

**The Inspector(s) also conducted a tour of resident care areas, observed the provision of care and services to residents, staff to resident interactions, reviewed relevant health care records, various licensee policies, procedures and programs and the home's medication incident reports and internal investigation files.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Infection Prevention and Control**
**Medication**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

**2 WN(s)**
**1 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

**Specifically failed to comply with the following:**

**s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,**
**(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).**
**(b) is complied with. O. Reg. 79/10, s. 8 (1).**

**Findings/Faits saillants :**

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

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

Specifically, staff did not comply with the licensee's policies regarding, "Shift Change Monitored Drug Count" last revised January 2018, "Medication Incident Reporting" last revised January 2018, "The Medication Pass" last revised January 2018, "Individual Monitored Medication Record" last revised January 2018, and "Drug Destruction and Disposal" last revised January 2018.

(A) Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director in March 2018, regarding a controlled substance missing/unaccounted, for resident #008. The CI report indicated that in March 2018 at a specific time, during a narcotic count, a narcotic card containing one 30 milligram (mg) tablet of a controlled substance was identified missing.

A review of the home's investigation file identified that in March 2018 at a specific time, RPN #109 who was leaving, and RPN #107 who was arriving, had completed a narcotic

count together and both had signed on a sheet titled, "Shift Change Monitored Medication Count" that resident #008 had one 30 mg tablet of a controlled substance remaining in their narcotic card.

A review of the home's policy titled, "Shift Change Monitored Drug Count" last revised January 2018, identified that two staff (leaving and arriving) together: (a) count the actual quantity of medications remaining, (b) record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Medication Count' form, (c) confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record'. Shift count was a means to regularly audit the individual count for accuracy.

During an interview with RPN #107, they stated that when the new controlled substances arrived from the pharmacy for resident #008, that they had counted the new narcotics arriving and started a new narcotic card, but could not find the old narcotic card for the 30 mg controlled substance that should have had one tablet remaining in it. As well, RPN #107 stated that the shift change narcotic count earlier that same evening had been quick and rushed. RPN #107 stated they had lost track of which controlled substance RPN #109 was referring to during the narcotic count, when they were recording the quantity of medications remaining. RPN #107 stated that RPN #109 may have thrown out the 30 mg controlled substance narcotic card that was to have contained 15 mg dosage of the same controlled substance, along with another empty narcotic card into the garbage, but they did not witness this.

During an interview with RPN #109, they were unaware that RPN #107 was having difficulty keeping track of the narcotic count. RPN #109 confirmed they had thrown out the empty 15 mg narcotic card into the garbage, but was unsure if they had thrown the 30 mg narcotic card containing the controlled substance with one tablet left, into the garbage.

During an interview with the Director of Care (DOC), they stated that there was a violation of the home's policy and that RPN #109 and RPN #107 did not conduct the narcotic count at shift change properly, as they rushed through it and did not ensure accuracy with the narcotic count. The DOC stated that possibly RPN #109 threw out the 30 mg controlled substance narcotic card out, into the garbage. The DOC stated that RPN #107 should have asked RPN #109 to slow down to ensure accuracy with the narcotics remaining and RPN #109 had rushed through the narcotic count and may have accidentally thrown the 30 mg narcotic card containing a tablet of the controlled

substance into the garbage, along with the empty 15 mg controlled substance narcotic card.

The missing/unaccounted controlled substance was not located.

(B) A further review of the home's investigation file revealed that there was no medication incident report completed for the controlled substance missing/unaccounted for resident #008.

A review of the home's policy titled, "Medication Incident Reporting" last revised January 2018, identified that the 'Medication Incident Report' was used to document any incident involving medication or adverse drug reaction regardless of origin. The 'Medication Incident Report' was reviewed, analyzed and included in the evaluation at the home in order to reduce and prevent medication incidents and adverse drug reactions. A 'Medication Incident Report' was to be completed online when a medication incident or adverse drug reaction has occurred.

During an interview with the DOC, they confirmed they were unable to locate an medication incident report on file and that there should have been a medication incident report completed at the time the medication incident was determined.

An incident report was completed during this inspection. The missing/unaccounted controlled substance did not have an impact on resident #008.

2. Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director in March 2018, regarding a controlled substance missing/unaccounted, for resident #001. The CI report indicated that in March 2018, it was discovered that one tablet of a controlled substance was missing from resident #001's medication card. It was identified that the medication incident had occurred the previous evening shift in March 2018, when RPN #112 was leaving and RPN #105 and RPN #111, were arriving to complete the remainder of the evening shift.

A review of the home's investigation file revealed that in March 2018 at a specific time, RPN #112 did not sign for a dose administration on the electronic Medication Administration Record (eMAR), but had signed on resident #001's Monitored Medication Record for 7-Day Card, as it having been administered. The Monitored Medication Record For 7-Day Card, also identified that RPN #111 had also signed for administering the one tablet of a controlled substance to resident #001 for the same date and time as

RPN#112.

During an interview with RPN #105, they stated that when they arrived to the unit, resident #001 had been at an appointment; therefore, the resident's hova somni (hs) medications were not administered until a later time, when the resident had returned. RPN #105 stated they had directed RPN #111 to administer the hs medications to resident #001, which they did.

A review of the home's policy titled, "The Medication Pass" last revised January 2018, revealed that registered staff were to ensure the resident was ready to take medications, locate medications and check each medication label against eMAR to ensure accuracy, administer medication and ensure that they are taken, document on the eMAR in the proper space for each medication administered or document by code if medication was not given.

A review of the home's policy titled, "Individual Monitored Medication Record" last revised January 2018, identified to document for the administration of the monitored medication on the resident's MAR and sign on the 'Individual Monitored Record' each time a dose was administered.

A review of the home's policy titled, "Drug Destruction and Disposal" last revised January 2018, identified that two nurses must document required information on the Count and on the Drug Destruction and Disposal Monitored Medication list when the medication was removed from the active orders in the cart and place the medication into a double locked monitored drug storage (ie. wooden box) in the locked medication room.

During an interview with RN #100, who was in an Assistant Director of Care (ADOC) role at the time of the incident, stated that upon their investigation, they had determined that RPN #112 had, pre-poured, the resident's medication, and had signed for them on the Monitored Record for 7-Day Card in March 2018 at a specific time but had not administered the hs medications, as the resident had been at an appointment. As well, RPN #112 had discarded the medication containing the controlled substance. RN #100 confirmed that RPN #112 had not followed the home's policy or expectations for proper administration and disposal of controlled substances.

During an interview with the Director of Care, they confirmed that RPN #112 had not followed the home's policy or expectations.

The missing/unaccounted controlled substance was not located. The missing/unaccounted controlled substance did not have an impact on resident #001.

3. Inspector #613 reviewed a CI report that was submitted to the Director in May 2018, regarding a controlled substance missing/unaccounted, for resident #009. The CI report indicated that two days earlier, it was discovered that one tablet of a controlled substance was missing from resident #009's narcotic card, during a shift change narcotic count by RPN #110, who was leaving and RPN #117, who was arriving. The CI report stated that the narcotic count sheet identified that one tablet was missing in the narcotic card blister package. It was identified that the seal of the blister package scheduled for a specific date and time had been opened and the controlled substance tablet was missing. The CI report identified that the narcotic card had been double locked in the narcotic bin of the medication cart in the locked medication room for the entirety of the night shift, with the exception of taking out the narcotic card to complete the narcotic count at shift change the day it was discovered missing.

A review of the home's internal investigation file identified that RPN#110 had completed a shift change narcotic count with RPN #118 who had worked the evening shift prior to the day of discovering the missing medication. It was written in the investigation file that RPN #110 had stated they did not look at the narcotic cards during the shift change narcotic count.

A review of the home's policy titled, "Shift Change Monitored Drug Count" last revised January 2018, identified that two staff (leaving and arriving) together: (a) count the actual quantity of medications remaining, (b) record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Medication Count' form, (c) confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record'. Shift count is a means to regularly audit the individual count for accuracy).

During an interview with ADOC #108, they stated that RPN #110 leaving their shift counted with RPN #118, who was arriving on the next shift and both had signed that the narcotic count was accurate. ADOC #108 stated the RPN #110 had not ensured accuracy with the narcotic count and had not completed the narcotic sheet accurately, as there had been one tablet of a controlled substance missing from the narcotic card. ADOC #108 stated they have not been able to complete their investigation as they were unable to contact RPN #110.

The missing/unaccounted controlled substance was not located. The missing/unaccounted controlled substance did not have an impact on resident #009. [s. 8. (1) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

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

Inspector #627 reviewed a CI report that was submitted to the Director in February 2018, alleging improper care to resident #007. The CI report indicated that resident #007 had been upset and had complained to PSW # 113 regarding being left unattended for an extended period of time in the dining room in February 2018.

During an interview with resident #007, they confirmed to the Inspector that being left unattended in the dining room after a specific meal service was a daily occurrence. The resident reported that they required certain care to be provided which did occur during this extended period of time when they were left unattended.

A review of resident #007's care plan in effect at the time of the alleged incident, identified under the focus for a specific activity of daily living, that resident #007 to receive assistance with two activities of daily living, after a meal service.

During an interview with PSW #116, they confirmed that resident #007 was left unattended for an extended period of time in the dining room, as the PSW assigned to care for the resident had suddenly left without notifying anyone and which led to some confusion. PSW #116 stated that they, along with PSW #115 had apologized to resident #007 for leaving them in the dining room. PSW #116 acknowledged that the resident required assistance with two activities of daily living and that was not done.

During an interview with the DOC, they stated that on the day of the incident, a PSW had walked out without notifying anyone. The staff on the floor thought resident #007 was being cared for, therefore they were not paying attention to them, until a specific time when they noticed the resident in the dining room. The DOC acknowledged that the resident was not provided the care that they required. [s. 6. (7)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.***

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**Issued on this 26th 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) :** | LISA MOORE (613), SYLVIE BYRNES (627) |
| **Inspection No. / No de l'inspection :** | 2018_395613_0013 |
| **Log No. / No de registre :** | 003870-18, 004716-18, 004910-18, 006432-18, 006572-18, 006629-18, 007043-18, 009636-18 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Jun 19, 2018 |
| **Licensee / Titulaire de permis :** | Extendicare (Canada) Inc.<br>3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9 |
| **LTC Home / Foyer de SLD :** | Extendicare York<br>333 York Street, SUDBURY, ON, P3E-5J3 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Tracy Lamirande |

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

**Order / Ordre :**

The licensee must be compliant with s. 8 (1) (b) of the Long -Term Care Homes Act (LTCHA).

Specifically, the licensee must:

a) ensure all registered staff maintain safe and accurate medication management for all controlled substances during shift count, receipt, storage, administration and destruction and disposal to optimize effective drug therapy outcomes for the residents.

b) ensure the home's "Shift Change Monitored Drug Count", “Drug Destruction and Disposal”, “Medication Incident Reporting”, “The Medication Pass”, “Individual Monitored Medication Record” policies any all other medication policies are complied with

c) the home's staff who are involved in the administration or destruction of medications review the above mentioned policies, and

d) the home maintains a record of all staff who were required to review the policies.

**Grounds / Motifs :**

1. The licensee has failed to ensure that where the Act or Regulation required

the licensee of a long-term care home to have institute or otherwise put in place any system, the system was complied with.

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

Specifically, staff did not comply with the licensee's policies regarding, "Shift Change Monitored Drug Count" last revised January 2018, "Medication Incident Reporting" last revised January 2018, "The Medication Pass" last revised January 2018, "Individual Monitored Medication Record" last revised January 2018, and "Drug Destruction and Disposal" last revised January 2018.

(A) Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director in March 2018, regarding a controlled substance missing/unaccounted, for resident #008. The CI report indicated that in March 2018 at a specific time, during a narcotic count, a narcotic card containing one 30 milligram (mg) tablet of a controlled substance was identified missing.

A review of the home's investigation file identified that in March 2018 at a specific time, RPN #109 who was leaving, and RPN #107 who was arriving, had completed a narcotic count together and both had signed on a sheet titled, "Shift Change Monitored Medication Count" that resident #008 had one 30 mg tablet of a controlled substance remaining in their narcotic card.

A review of the home's policy titled, "Shift Change Monitored Drug Count" last revised January 2018, identified that two staff (leaving and arriving) together: (a) count the actual quantity of medications remaining, (b) record the date, time, quantity of medication and sign in the appropriate spaces on the 'Shift Change Monitored Medication Count' form, (c) confirm actual quantity is the same as the amount recorded on the 'Individual Monitored Medication Record'. Shift count was a means to regularly audit the individual count for accuracy.

During an interview with RPN #107, they stated that when the new controlled substances arrived from the pharmacy for resident #008, that they had counted the new narcotics arriving and started a new narcotic card, but could not find the old narcotic card for the 30 mg controlled substance that should have had one

tablet remaining in it. As well, RPN #107 stated that the shift change narcotic count earlier that same evening had been quick and rushed. RPN #107 stated they had lost track of which controlled substance RPN #109 was referring to during the narcotic count, when they were recording the quantity of medications remaining. RPN #107 stated that RPN #109 may have thrown out the 30 mg controlled substance narcotic card that was to have contained 15 mg dosage of the same controlled substance, along with another empty narcotic card into the garbage, but they did not witness this.

During an interview with RPN #109, they were unaware that RPN #107 was having difficulty keeping track of the narcotic count. RPN #109 confirmed they had thrown out the empty 15 mg narcotic card into the garbage, but was unsure if they had thrown the 30 mg narcotic card containing the controlled substance with one tablet left, into the garbage.

During an interview with the Director of Care (DOC), they stated that there was a violation of the home's policy and that RPN #109 and RPN #107 did not conduct the narcotic count at shift change properly, as they rushed through it and did not ensure accuracy with the narcotic count. The DOC stated that possibly RPN #109 threw out the 30 mg controlled substance narcotic card out, into the garbage. The DOC stated that RPN #107 should have asked RPN #109 to slow down to ensure accuracy with the narcotics remaining and RPN #109 had rushed through the narcotic count and may have accidentally thrown the 30 mg narcotic card containing a tablet of the controlled substance into the garbage, along with the empty 15 mg controlled substance narcotic card.

The missing/unaccounted controlled substance was not located.

(B) A further review of the home's investigation file revealed that there was no medication incident report completed for the controlled substance missing/unaccounted for resident #008.

A review of the home's policy titled, "Medication Incident Reporting" last revised January 2018, identified that the 'Medication Incident Report' was used to document any incident involving medication or adverse drug reaction regardless of origin. The 'Medication Incident Report' was reviewed, analyzed and included in the evaluation at the home in order to reduce and prevent medication incidents and adverse drug reactions. A 'Medication Incident Report' was to be completed online when a medication incident or adverse drug reaction has

occurred.

During an interview with the DOC, they confirmed they were unable to locate an medication incident report on file and that there should have been a medication incident report completed at the time the medication incident was determined.

An incident report was completed during this inspection. The missing/unaccounted controlled substance did not have an impact on resident #008.

2. Inspector #613 reviewed a Critical Incident (CI) Report that was submitted to the Director in March 2018, regarding a controlled substance missing/unaccounted, for resident #001. The CI report indicated that in March 2018, it was discovered that one tablet of a controlled substance was missing from resident #001's medication card. It was identified that the medication incident had occurred the previous evening shift in March 2018, when RPN #112 was leaving and RPN #105 and RPN #111, were arriving to complete the remainder of the evening shift.

A review of the home's investigation file revealed that in March 2018 at a specific time, RPN #112 did not sign for a dose administration on the electronic Medication Administration Record (eMAR), but had signed on resident #001's Monitored Medication Record for 7-Day Card, as it having been administered. The Monitored Medication Record For 7-Day Card, also identified that RPN #111 had also signed for administering the one tablet of a controlled substance to resident #001 for the same date and time as RPN#112.

During an interview with RPN #105, they stated that when they arrived to the unit, resident #001 had been at an appointment; therefore, the resident's hova somni (hs) medications were not administered until a later time, when the resident had returned. RPN #105 stated they had directed RPN #111 to administer the hs medications to resident #001, which they did.

A review of the home's policy titled, "The Medication Pass" last revised January 2018, revealed that registered staff were to ensure the resident was ready to take medications, locate medications and check each medication label against eMAR to ensure accuracy, administer medication and ensure that they are taken, document on the eMAR in the proper space for each medication administered or document by code if medication was not given.

A review of the home's policy titled, "Individual Monitored Medication Record" last revised January 2018, identified to document for the administration of the monitored medication on the resident's MAR and sign on the 'Individual Monitored Record' each time a dose was administered.

A review of the home's policy titled, "Drug Destruction and Disposal" last revised January 2018, identified that two nurses must document required information on the Count and on the Drug Destruction and Disposal Monitored Medication list when the medication was removed from the active orders in the cart and place the medication into a double locked monitored drug storage (ie. wooden box) in the locked medication room.

During an interview with RN #100, who was in an Assistant Director of Care (ADOC) role at the time of the incident, stated that upon their investigation, they had determined that RPN #112 had, pre-poured, the resident's medication, and had signed for them on the Monitored Record for 7-Day Card in March 2018 at a specific time but had not administered the hs medications, as the resident had been at an appointment. As well, RPN #112 had discarded the medication containing the controlled substance. RN #100 confirmed that RPN #112 had not followed the home's policy or expectations for proper administration and disposal of controlled substances.

During an interview with the Director of Care, they confirmed that RPN #112 had not followed the home's policy or expectations.

The missing/unaccounted controlled substance was not located. The missing/unaccounted controlled substance did not have an impact on resident #001.

3. Inspector #613 reviewed a CI report that was submitted to the Director in May 2018, regarding a controlled substance missing/unaccounted, for resident #009. The CI report indicated that two days earlier, it was discovered that one tablet of a controlled substance was missing from resident #009's narcotic card, during a shift change narcotic count by RPN #110, who was leaving and RPN #117, who was arriving. The CI report stated that the narcotic count sheet identified that one tablet was missing in the narcotic card blister package. It was identified that the seal of the blister package scheduled for a specific date and time had been opened and the controlled substance tablet was missing. The CI report

identified that the narcotic card had been double locked in the narcotic bin of the medication cart in the locked medication room for the entirety of the night shift, with the exception of taking out the narcotic card to complete the narcotic count at shift change the day it was discovered missing.

A review of the home's internal investigation file identified that RPN#110 had completed a shift change narcotic count with RPN #118 who had worked the evening shift prior to the day of discovering the missing medication. It was written in the investigation file that RPN #110 had stated they did not look at the narcotic cards during the shift change narcotic count.

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During an interview with ADOC #108, they stated that RPN #110 leaving their shift counted with RPN #118, who was arriving on the next shift and both had signed that the narcotic count was accurate. ADOC #108 stated the RPN #110 had not ensured accuracy with the narcotic count and had not completed the narcotic sheet accurately, as there had been one tablet of a controlled substance missing from the narcotic card. ADOC #108 stated they have not been able to complete their investigation as they were unable to contact RPN #110.

The missing/unaccounted controlled substance was not located. The missing/unaccounted controlled substance did not have an impact on resident #009. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2 as a potential for actual harm. The scope of the issue was level 3 as it was widespread. The home had a level 3 history as they had on-going non-compliance with this section of the LTCHA that included:
-written notification (WN) issued February 28, 2018 (2018_657681_003);
-compliance order (CO) issued October 25, 2016 (2016_282542_0023);
-voluntary plan of correction (VPC) issued August 30, 2016

-VPC issued September 18, 2015 (2015_391603_0024).
(613)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 27, 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 19th day of June, 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 :** Lisa Moore

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