Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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
Nov 13, 2019	2019_680687_0029	019063-19	Critical Incident System

Licensee/Titulaire de permis

Foyer Hearst - Mattice - Soins De Sante
67-15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

Foyer Des Pionniers
67 15th Street P.O. Box 1538 HEARST ON P0L 1N0

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

LOVIRIZA CALUZA (687)

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): October 29, 2019.

The following intake was inspected during this Critical Incident System (CIS) Inspection.

- One intake related to missing controlled substances.

During the course of the inspection, the inspector(s) spoke with the Administrator/Assistant Director of Care (ADOC), the Director of Care (DOC), Registered Nurses (RNs) and Registered Practical Nurses (RPNs).

The Inspector conducted a daily tour of resident care areas, observed the provision of care and services to residents, reviewed relevant health care records, as well as the home's internal investigation and policies.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **0 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 :

1. The licensee has failed to ensure that where the Long-Term Care Homes Act (LTCHA) or Ontario Regulation (O. Reg) 79/10 required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, system, policy, protocol, procedure, strategy or system was complied with.

Specifically, staff did not comply with the home's "Administration of Medication" policy (Code: 05-02-03) last reviewed in June 2018.

The home submitted a Critical Incident (CI) report to the Director, regarding missing specified medications from the home. The CI indicated that Registered Practical Nurse (RPN) #104 was found in unlawful possession of a specified medication that belonged to a resident from the home.

The Inspector identified that on a specified date, resident #003's specified medications were taken from resident #003's medication card and administered to resident #002 (for which, resident #002 had a prescribed order) on two occasions by RPN #102, and RPN #105 respectively. Additionally, on a specified date, another dose of resident#003's specified medication was taken from resident #003's medication card and administered to resident #004 (for which, resident #004 had a prescribed order) by another registered staff member.

In a record review of the home's policy titled "Administration of Medication" last reviewed in June 2018, indicated that "The name of the medication on the Electronic Medication Administration Record (E-MAR) should match the name of the medication in the card."

Inspector #687 interviewed RPN #102, who stated that they had borrowed two separate doses from resident #003's specified medication and had administered it to resident #002 as the resident's medication supply was not delivered by the pharmacy on time.

During an interview with RPN #105 and RN #103, they stated that if a specified medication was required for a resident and the pharmacy had not sent them the resident's medication supply, the registered staff would borrow a specific medication from another resident until the resident's medication supply arrived from the pharmacy.

In an interview with the Director of Care (DOC), they stated that registered staff were not supposed to borrow medications from other residents. The DOC further stated that the registered staff were supposed to call or send a fax to the pharmacy to obtain the resident's medication supply and that the pharmacy was supposed to provide service and deliver the required medications for the residents in the home. [s. 8. (1) (a)]

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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to inform the Director within 10 days of becoming aware of the incident, a description of the individuals involved in the incident including the names of any resident involved in the incident.

The home submitted a CI report to the Director, regarding missing specified medications from the home. The CI indicated that Registered Practical Nurse (RPN) #104 was found in unlawful possession of a specified medication that belonged to a resident from the home.

Inspector #687 reviewed the CI report submitted to the Director regarding the missing specified medications from the home but the Inspector did not identify the name of any resident involved in the incident.

A review of the home's internal investigation conducted by Inspector #687, indicated that resident #002, #005, #006, #007, and #008's were identified who had specific medications that went missing.

During an interview with Inspector #687, the DOC indicated that in their internal investigation, they initially identified that resident #007 was missing their specified medication. The DOC stated that they conducted further investigation and identified other residents were also missing specific medications which included resident #002, #005, #006 and #008. The DOC acknowledged that they had not listed any resident names in the CI report. [s. 107. (4) 2. i.]

WN #3: 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, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The home submitted a CI report to the Director, regarding missing specified medications from the home. The CI indicated that Registered Practical Nurse (RPN) #104 was found in unlawful possession of a specified medication that belonged to a resident from the home.

During separate observations of the Medication Rooms, Inspector #687 observed RPN #102 and RN #103 open a specified storage area where the discontinued specified medications were stored. The Inspector observed that the specified storage area had two locks; however, the same key was used to open both locks.

A review of the home's policy titled "Drug Destruction" reviewed date on June 2018, indicated that "Narcotics and Controlled drugs must be double locked as per narcotic storage regulations."

In an interview with RPN #102, they stated that they stored the residents' discontinued specified medications in a specified storage area that had two locks which could be opened with one key.

During an interview with RN #103, they stated that they stored the residents' discontinued specified medications in a specified storage area with two locks, which could be opened with one key. The RN further stated that prior to the CI report, the residents' discontinued specified medication were stored in a specified single-locked storage area.

In an interview with the DOC, they stated that the registered staff were not supposed to store the residents' discontinued specified medication in the locked specified storage area of the Medication Room, but were supposed to store them in a specified storage area which was double locked. [s. 129. (1) (b)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

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

The home submitted a CI report to the Director, regarding missing specified medication from the home. The CI indicated that Registered Practical Nurse (RPN) #104 was found in unlawful possession of a specified medication that belonged to a resident from the home.

Inspector #687 conducted a review of the home's internal investigation and did not identify any monthly audit reports of the home's specified medications.

During an interview conducted by Inspector #687 with the Pharmacist, they stated that there was no official documentation of the home's monthly audit reports for the specified medications.

In an interview conducted by Inspector #687 with the DOC, they stated that the specified medication audit reports were being done by the Pharmacist. The DOC further stated that the specified medication audit reports should have been done every month but they had not received any monthly audit reports from the Pharmacist. [s. 130. 3.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(a) in the case of a controlled substance, subject to any applicable requirements under the Controlled Drugs and Substances Act (Canada) or the Food and Drugs Act (Canada),
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) a physician or a pharmacist; and O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were destroyed by one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist.

The home submitted a CI report to the Director, regarding missing specified medications from the home. The CI indicated that Registered Practical Nurse (RPN) #104 was found in unlawful possession of a specified medication that belonged to a resident from the home.

Inspector #687 conducted an observation in two Medication Rooms and did not observe any Drug Destruction Storage Box.

In a review of the home's policy titled "Drug Destruction", reviewed date in June 2018, it indicated that "Surplus medications were destroyed by the Director of Care and a pharmacist or physician".

Inspector #687 interviewed RPN #102 and RN #103, who stated that the Pharmacist would pick-up the discontinued specified medications from the Medication Rooms and they took them for drug destruction outside the home to an unknown location.

Inspector #687 interviewed the Pharmacist, who stated that they would pick-up the discontinued specified medications from the Medication Rooms and they took them out of the home for drug destruction. The Pharmacist further stated that another Pharmacist would co-sign with them for the discontinued specified medication for the drug destruction.

In an interview with the DOC, they stated that the Pharmacist would pick-up the residents' discontinued specified medication from the Medication Rooms and took them for drug destruction. The DOC further stated that the drug destruction of the specified medication occurred outside of the home and that two pharmacists would sign for it. The DOC stated that their notion was that two pharmacists could sign the drug destruction of the discontinued specified medication outside of the home, and that this was okay. [s. 136. (3) (a)]

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.