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**

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300


**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Feb 6, Aug 15, 2017 | 2016_254610_0033 | 029630-16 | Critical Incident System |

**Licensee/Titulaire de permis**

MEADOW PARK (LONDON) INC
689 YONGE STREET MIDLAND ON L4R 2E1

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

MEADOW PARK (LONDON) INC.
1210 SOUTHDALE ROAD EAST LONDON ON N6E 1B4

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

NATALIE MORONEY (610), NEIL KIKUTA (658), RHONDA KUKOLY (213)

## 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 28, 31, November 1, 2, 3, 8, 9, 15, 16, 17, 18, 30, December 1, 2, 5, 6, 7, 8, 16, 19, 21, 22, 2016, and January 5, 6, 10, 11, 12, 13, 16, 17, 18, 20, 25, 27, 30, 31, February 1, 2, 8, 10, 13, 14, 15, 16, 22, and 23, 2017.**

**This Critical Incident was inspected related to Medication, Reporting and Complaints, Critical Incidents, Hospitalization and Change in Condition.Medication, Training and Orientation, Critical Incident Response Reporting, and Sufficient**

**Staffing.**

**The following Complaint inspections were conducted concurrently during the course of this inspection:**

**Complaint Log #027003-16 IL #46493-LO related to alleged abuse.**
**Complaint Log #030802-16 IL-#47518-LO related to alleged abuse.**
**Complaint Log #033880-16 IL #48305-LO related to alleged abuse.**
**Complaint Log #033785-16 IL #48278-LO related to alleged abuse.**

**The following Critical Incident inspections were conducted concurrently during the course of this inspection:**

**Critical Incident Log #028004-16 CIS #2643-000025-16 related to alleged abuse.**
**Critical Incident Log #030414-16 CIS #2643-000028-16 related to alleged abuse.**
**Critical Incident Log #030415-16 CIS #2643-000029-16 related to alleged abuse.**
**Critical Incident Log #030857-16 CIS #2643-000009-17 related to alleged abuse.**
**Critical Incident Log #031648-16 CIS #2643-000032-16 related to alleged abuse.**
**Critical Incident Log #000391-17 CIS #2643-000001-17 related to alleged abuse.**
**Critical Incident Log #003230-17 CIS #2643-000005-17 related to alleged abuse.**
**Critical Incident Log #004430-17 CIS #2643-000010-17 related to alleged abuse.**
**Critical Incident Log #006739-17 CIS #2643-000016-17 related to alleged abuse.**
**Critical Incident Log #030906-16 CIS #2643-000031-16 related to alleged abuse.**

**During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, the Director of Long Term Care Operations, the Care Services Coordinator, the Administrator, the Director of Care, the acting Administrator, a previous Administrator, a previous Director of care, a previous Co-Director of Care, two Lawyers, two Physicians, the Pharmacy Consultant, the Co-Director of Care, the Restorative Care Coordinator, the Environmental Services Supervisor, two Staff Educators, the Registered Dietitian, the Administrative Assistant, three Registered Nurses, 11 Registered Practical Nurses, and 18 Personal Support Workers, families, and residents.**

**During the months of October, November, December 2016, January, and February 2017, inspectors completed observations of the medication rooms, medication carts, medication administration, drug destruction of controlled substances and non-controlled drug substances, documentation related to signage of ordering and**

**receiving medication from pharmacy, documentation for medication administration on the Electronic Medication Administration Record (eMAR), and signage of controlled substances by the registered staff. Completed health care record reviews, resident care observations and any other relevant documentation at that time of the inspection. From the record reviews, interviews, and observations, non-compliance with the following requirements was identified.**

**The following Inspection Protocols were used during this inspection:**
**Critical Incident Response**
**Hospitalization and Change in Condition**
**Medication**
**Reporting and Complaints**
**Sufficient Staffing**
**Training and Orientation**

**During the course of this inspection, Non-Compliances were issued.**
- **8 WN(s)**
- **7 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 LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

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

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

1.The licensee failed to ensure that residents were protected from abuse by anyone and that residents were not neglected by the licensee or staff.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specific date, the medication reconciliation and admission order form showed that an identified resident was to have a catheter change every six weeks and staff were to monitor catheter output every shift however, there was no physician's order that included the size and type of catheter to be used and registered staff neglected to clarify the order with the physician.

The minimum data set (MDS) assessment completed on a specific date showed that the resident had a specific type and size of catheter. The resident assessment protocol (RAP) completed on a specific date stated that the catheter was inserted prior to the resident's admission to the home and was being monitored, irrigated and emptied every shift.

The resident's care plan for toileting was not initiated until twenty six days after the resident was admitted to the home. It stated the resident required assistance/potential to restore function to maximum self-sufficiency for the physical process of toileting. There were no goals or interventions/tasks identified for the catheter use nor did it provide clear direction for staff in managing the care of the catheter.

A review of the resident's health record showed that the home was provided patient follow up information on admission that included recommendations to the nursing home. The information provided directions for staff to remove the catheter at a specific date and time and to check post void residual and if the resident did not void over a specific period of time staff were to re-insert the catheter. The resident was to have a follow up appointment with the specialist to reassess. Three specific medications were to be held and staff were to monitor and re-start the medication if needed.

Review of the identified resident's health record showed that these instructions were neglected to be transcribed into the physician's orders and the catheter was not removed on the specific date, as recommended upon admission.

A physician's order on a specific date stated to change the catheter and send a sample for testing. On the same date, a progress note completed by a registered staff member showed that the physician's order was received and the procedure completed at a specific time. When removing the catheter a drainage of a specific substance was noted.

Further, a certain sized catheter was inserted with an order from the physician to flush the catheter every shift and monitor and record output every shift.

Review of progress notes showed the following:

Over a twenty day period there were at least 45 shifts that did not include the recorded output of the resident.

On a specific date urine results showed that the identified resident had an infection and an antibiotic was initiated.

On a specific date a registered staff member documented that the resident's catheter fell out and they did not reinsert the catheter until three and half hours later at the resident's request. The registered staff member documented that a certain sized catheter was inserted.

On that same date, it showed that the size of the catheter inserted was different from the size of the catheter inserted previously and on both occasions, registered staff neglected to contact the physician to clarify the size of the catheter to be inserted for the resident.

On a specific date, the identified resident was screaming and stated that they could not sleep.

The next day, the resident received pain medication because the resident was intermittently calling out, sleeping poorly, moaned and groaned when the catheter slightly moved. Documentation showed the medication was ineffective and the resident was still calling out intermittently and sleeping poorly. There was no pain assessment initiated and there was no further monitoring or action initiated.

Three days later, the identified resident was yelling out at the start of the shift but then settled on their own.

The next day, the identified resident received pain medication because the resident was loudly moaning, groaning and screaming. Documentation stated that the registered staff member was unable to tell if the resident was in pain. The resident was sleeping approximately six and half hours later.

Two days later, the identified resident received pain medication because the resident

moaning, groaning and screaming. Documentation stated that the resident was probably in discomfort. Three hours later documentation showed the medication was ineffective and the resident was still intermittently moaning, groaning and screaming. The registered staff member documented that they were uncertain if it was discomfort or behavior. There was no pain assessment initiated and there was no further monitoring or action initiated.

Three days later, the identified resident received pain medication because the resident was moaning, calling out loudly, unable to sleep well due to noise and given medication for comfort. Two hours later documentation showed the medication was ineffective and the resident was still intermittently moaning and calling out. There was no pain assessment initiated and there was no further monitoring or action initiated.

Approximately six hours later, the identified resident received pain medication because the resident complained of generalized pain. There was no pain assessment initiated.

Approximately eight hours later, the identified resident's death was pronounced.

A review of the resident's health record showed there was a pain assessment completed upon admission however, there was no other pain assessment completed for the identified resident despite signs of onset pain and receiving as needed (PRN) medication for pain on at least six occasions over a 10 day period.

A review of the identified resident's plan of care showed that there was no focus for pain including goals and interventions/tasks for the management of pain.

On a specific date, the identified resident had a specialist appointment and returned with initial patient care orders to change the catheter every four to six weeks and directions for staff to provide treatment for impaired skin integrity.

Review of the resident's physician orders showed that the recommendations for changing the catheter from the specialist were not ordered and review of the resident's plan of care showed there was no interventions related to the recommended treatment of the resident's impaired skin integrity.

Review of the resident's health record showed there was no further documentation or treatment related to the resident's skin impairment after returning to the home from their appointment.

The licensee failed to ensure that the identified resident was not neglected by staff and failed to ensure they were provided with the treatment, care, services or assistance required for the health or well-being. This includes a pattern of inaction that jeopardized the health and well-being of the resident.

The severity of this non-compliance was actual harm and the scope was isolated. The home does not have a history of non-compliance in this subsection of the legislation.

***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 residents are not neglected by the licensee or staff, to be implemented voluntarily.***

---

**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that a person who had reasonable grounds to suspect

abuse of a resident by anyone that resulted in harm or a risk of harm to a resident, immediately reported the suspicion and the information upon which it was based to the Director.

During the inspection, inspectors reviewed the licensee's current policies and procedures in the home for zero tolerance of abuse, education that staff received regarding allegations of abuse, as well as reporting the allegations of abuse. Inspectors reviewed resident health care records, critical incidents and conducted interviews.

From the record reviews, interviews, and observations, the following incidents of abuse of a resident were not immediately reported to the Director.

1) On a specific date, a registered staff member who was aware of an allegation of physical abuse, documented in an identified resident’s progress notes that a visitor of the resident had pushed and yelled at another resident of the home. The registered staff member, who was in charge on the evening shift, approached the visitor and had documented that the visitor yelled at them aswell as a second resident and that management was aware of this incident.

2) On a specific date, a registered staff member documented in an identified resident’s progress notes that the resident was observed to be left in bed in a restraining position. The registered staff member who was in charge at the time the resident was observed wrote a progress note that documented that they had told the home's management about the incident.

3) On a specific date, a registered staff member documented an incident of alleged touching of one resident to another resident in an identified resident’s progress notes. The registered staff member who was in charge at the time the resident was observed wrote a progress note that documented that they had told the home's management about the incident.

The licensee's policy for Abuse Zero Tolerance effective date September16, 2013, states in part that staff who have reasonable grounds to suspect abuse or neglect of a resident would immediately notify the most senior personnel, notify the SDM, physician, and commence an immediate investigation. The Administrator or Director of Care would notify the Ministry's Regional Office via Unusual Occurrence Form within the required time frames as required.

The licensee's policy for Abuse Zero Tolerance is not consistent with s. 24 of the LTCH Act which requires a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

During a telephone interview with the DOC, they said they could not recall the incident regarding a family member of the identified resident pushing and yelling at another resident of the home.

The Administrator, DOC, and Co-DOC said they were not aware of the incident where the RN observed an identified to be left in bed in a restraining position. In an interview with the SDM for the resident, they said they were also not aware of the resident being left in bed in a restraining position.

The Director of Care said that the licensee was aware of the incident involving the alleged sexual abuse and had thought that a critical incident report was submitted to the Director.

The Administrator said that any allegations of abuse are to be reported to the management staff and that if the incidents occurred after hours the registered staff member in charge was to notify the on call manager.

The Administrator stated it was the responsibility of the administrator to submit the critical incidents to the Director for all allegations of abuse.

The Administrator said that they do not have a critical incident with internal investigations notes in regards to the allegations of sexual abuse and do not have any records of internal investigation or information that was provided to the Director for the family member pushing a resident of the home.

The licensee failed to ensure that a person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or a risk of harm to a resident immediately reported the suspicion and the information upon which it was based to the Director.

The severity of this non-compliance was minimal harm and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation, it

was issued as a Written Notification on February 13, 2015, during a complaint inspection #2015_254610_0006.

***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 a person who has reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

---

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management**

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

**s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that when a resident's pain was not relieved by initial interventions,the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

During the inspection, inspector #610 completed observations of the medication rooms, medication carts, medication administration, documentation for medication administration on the eMAR, signage of controlled substances by the registered staff, resident health care records for plan of care and identified areas of risk with findings of non-compliance.

A pain assessment for an identified resident was completed on admission. The assessment showed that the resident was receiving pain medication for specific diagnoses and that the resident had expressed pain throughout their body. The pain

scale showed that the resident experienced moderate pain that was to be managed by administering pain medication as prescribed.

On a specific date, the physician documented on the Annual Physical and Treatment Plan that the identified resident was in the end stages of their disease.
A week later, the physician documented in the progress notes that the resident was experiencing a specific symptom and had requested that the current pain medication order be increased. The physician increased the resident’s dosage of pain medication.

Three weeks later, the physician documented in the resident's progress notes that the resident was requesting to receive the pain medication at a specific time and that the specific symptom was getting worse. Review of the resident’s health record shows there was no pain assessments completed using a clinically appropriate assessment instrument specifically designed for pain when the resident was experiencing pain and had a change in condition.

The administration of a pain medication was to be given twice a day at specific times. Approximately three months later, a RPN documented in the progress notes that both doses were omitted and not administered to the resident. The progress notes stated that the first dose was "given by the night nurse" and the second dose was not administered as it was "past the administration time". There was no further documentation to show that the physician was notified or that the resident’s pain had been assessed.

A review of the resident’s health record shows there was no completed pain assessment using a clinically appropriate assessment instrument specifically designed for pain.

A month later, the progress note shows that the resident had a specific symptom and was provided a stat dose of a medication.

On the same day the resident's progress notes showed that the resident had become unresponsive and was receiving comfort measures. A review of the resident’s health records shows there was no pain assessment completed using a clinically appropriate assessment instrument specifically designed for pain.

The licensee policy for the Pain Management Program, Revised 2016-03-11 states in part that: Screening for Pain in residents would be completed for residents who experience a significant change of condition and that the resident would have a comfort care measure indicated as part of the plan of care. The plan of care would be updated to

include type, location, severity, pattern of pain, including diagnosis, quantifiable and measurable goal, ways to monitor pain, and strategies related to pain management.

Review of the residents' plan of care showed that the resident had pain related to two areas however; there was no plan of care regarding the medication management for pain, intervention on how to manage the pain, screening for pain, comfort care measures, health conditions, site of pain, or directions for staff and others who provide direct care to the resident related to pain.

Further review of the Care Plan showed that the diagnosis was not identified in the plan of care. The signs and symptoms related to the diagnosis and the interventions to help assist the resident and staff with providing care was not part of the care plan related to the medication administration and therapy that was ordered by the physician.

The DOC said that the identified resident's plan of care should show that the resident had pain all over, was palliative and would be receiving palliative care, and that the resident's disease and diagnoses would be part of the plan of care and was not.

On a specific date and time, the documentation in the progress notes showed that the resident had pain all over and was provided pain medication. Two hours later, the pain medication provided to the resident was documented as ineffective and the resident was provided another dose at a specific time. It was noted that the pain medication provided was also ineffective. There was no pain assessment completed using a clinically appropriate assessment instrument specifically designed for pain.

Ten days later, pain medication was provided and was documented as being ineffective two hours later. The plan of care related to the pain and the end of life care was still not part of the plan of care for the resident at this time. The resident's pain was assessed as being 10/10 and the physician was called. An order for pain medication was received and provided to the resident.

Approximately four hours later, the identified resident deceased.

The licensee failed to ensure that when the identified resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

The severity of non-compliance was minimal harm or potential for actual harm, and the

scope was isolated. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction on February 9, 2016 during a Resident Quality Inspection #2016_457630_0003.

***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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.***

---

**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

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

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**
**2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).**
**3. A response shall be made to the person who made the complaint, indicating,**
**i. what the licensee has done to resolve the complaint, or**

**ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).**

**s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:**
**1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).**

**s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,**
**(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).**
**(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).**
**(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).**
**(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).**
**(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).**
**(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).**

**s. 101. (3) The licensee shall ensure that,**
**(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).**
**(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).**
**(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).**

**Findings/Faits saillants :**

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or

risk of harm to one or more residents, the investigation shall be commenced immediately.

Record review showed that an identified resident had a change in condition on a specific date, was sent to the hospital and the resident deceased in hospital the following day.

On a specific date, the long term care home received a written complaint from the resident's Substitute Decision Maker (SDM) addressed to the DOC. The written complaint from the SDM stated in part that they have serious concerns about the medical care the resident received at the home prior to the resident's death.

Forty five days after receiving the letter, the DOC sent an email to the Co- DOC stating in part that they did not respond to the complaint letter. The licensee did not address the concerns identified in the complaint letter according to the email from DOC, and did not conduct an investigation into the concerns or provide a response to the complainant.

On a specific date, the SDM spoke with the Co-DOC again regarding concerns related to care for the resident leading up to their death and requested the home to provide the resident's clinical notes.

Further review of the paper health care record and Point Click Care documentation showed that there was no response to the written complaint.

Further review of the home's complaints records showed that the home did not respond in writing to the complainant.

The licensee failed to keep a written record of this complaint, was not able to produce a written record of the investigation or the action taken and failed to provide a response within ten days of the receipt of the complaint.

2.The licensee has failed to ensure that a documented written or verbal complaint record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time
frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

The inspectors asked the Administrator for the home's complaints binder since 2014,

including the follow up to the complaints, and the home's policies and procedures. The same documentation was requested from the Administrator during an interview the following day.

Review of the Jarlette Health Services Reporting and Complaints Version 3, with an effective date of 04/01/2014, and a revised date of 2015-06-12, outlined in part that the Administrator would ensure that a written record was kept of each review and of the improvements made in response.

On a specific date, the Administrator provided the inspectors with the home's complaint binder. The Administrator said that they were still looking for a record of written and verbal complaints for 2014 and 2015.

Documentation within the home's complaint binder contained typed and hand written complaints dating from December 2, 2015, to November 1, 2016.
The Administrator said that they were not able to produce any further records of written and verbal complaints for 2014 and 2015 as they had not been kept. The Administrator told the inspector they did not have a written record of complaints.

The licensee has failed to ensure that a documented written or verbal complaint record was kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant.

3.The licensee has failed to ensure that every written or verbal complaint made to the licensee or astaff member concerning the care of a resident or operation of the home is dealt with and thedocumented record is reviewed and analyzed for trends at least quarterly.

Review of the Jarlette Health Services Reporting and Complaints Version 3, with an effective date of 04/01/2014, and a revised date of 2015-06-12, states in part that the Administrator would ensure that the concerns/complaint log was reviewed and analyzed for trends quarterly at a Risk Meeting with an annual summary and analysis completed at the December meeting.

The inspectors asked the Administrator for the home's complaints binder with logged complaints since 2014 and for the review and analysis of trends on a quarterly basis.

The same documentation was requested from the Administrator during an interview the following day.

During an interview with the Administrator, they acknowledged that they were to be completing quarterly reviews of the concerns and complaint log, but did not know if an analysis had been done and was not able to produce any documentation of analysis of trends for 2014 and 2015.

The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with and the documented record is reviewed and analyzed for trends at least quarterly.

The severity of this non-compliance was minimum risk, and the scope was widespread. The home does have a history of non-compliance in this subsection of the legislation, it was issued as a Voluntary Plan of Correction on July 5, 2016 during complaint inspection #2016_457630_0026

***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 every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows: 1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately; 2. A documented written or verbal complaint record is kept in the home that included the nature of each verbal or written complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant; 3. That every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with and the documented record is reviewed and analyzed for trends at least quarterly, to be implemented voluntarily.***

---

**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation**

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

**s. 116. (3) The annual evaluation of the medication management system must,**
**(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).**
**(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).**
**(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).**

**s. 116. (5) The licensee shall ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented. O. Reg. 79/10, s. 116 (5).**

**Findings/Faits saillants :**

The Licensee failed to ensure that the annual evaluation of the medication management system included: a) a review of the quarterly evaluations from the previous year; b) use an assessment instrument designed specifically for this purpose; and c) identify changes to improve the system in accordance with evidence- based practices and, if there are none, in accordance with prevailing practices.

During the inspection, inspectors #658 and #610 completed observations of the medication rooms, medication carts, medication administration, controlled and non-controlled drug substance destruction, documentation related to signage of ordering and receiving medication from pharmacy, documentation for medication administration on the EMAR, and signage of controlled substances by the registered staff. There are identified areas of risk with findings of non-compliance.

Further review of the licensee's annual evaluation on the medication management programs showed that the licensee had not completed the review for 2014 and 2015, and that the audit procedures had not been conducted, implemented or evaluated. The lack of evidence provided from the Administrator for the reviews showed that the licensee could not provide a statement that the management team supports the effective medication management program in the home.
Interviews were conducted in the home with the Administrator, DOC, Pharmacy Consultant and registered staff. These interviews showed that the policies and

procedures related to the management of the medication program were not clearly understood.

The licensee policy for Resident Rights, Care, and Services: Medication Management Evaluations of Pharmacy Services revised 2013-10-07 states that, the Administrator will:

*Seek input from the multidisciplinary team to determine the level of satisfaction with the provision of services by the contracted pharmacy vendor.

*Arrange a meeting with the contracted pharmacy vendor to discuss input received from the multidisciplinary team, provide feedback relative to the provisions of pharmacy services within the home, identify effectiveness of the services provided and efforts made to improve services.

*Document the outcomes of the meeting in written communication to the contracted pharmacy vendor.

Provide a report to the Pharmacy and Therapeutics Committee summarizing the outcomes of the above.

Further review of the Medication Management Program for Quality Improvement showed that there was no written record of the annual review for 2014 and 2015.

The Administrator provided the inspectors with the tool used for the medication management program annual review provided through the Institute for Safe Medication Practices (ISPM) Canada. The date on the ISMP was 2014-12-16. The Administrator had not been able to provide the written record for 2014 or 2015, of the results of the annual evaluation and of any changes that were implemented.

The Administrator was not able to provide the 2015 ISMP tool used to conduct the evaluation for the home; and the Administrator could not provide any records to support that the annual review in 2015, identified changes to improve the system in accordance with evidence-based practices or in accordance with prevailing practices.

When asked of the licensee if they had any other records of the 2014 and 2015 annual evaluations of the effectiveness of the medication management system in the home, the Administrator said during an interview that they provided what records they could.

The licensee failed to ensure that an assessment instrument designed specifically for evaluation of the medication management system had been used in 2015 for the annual evaluation; did not include a review of the quarterly evaluations in the previous year as referred; they had not identified changes to improve the system in accordance with evidence-based practices or in accordance with prevailing practices; and that a written record was kept of the results of the annual evaluation for 2014 and 2015 and of any changes that were implemented.

2.The licensee failed to ensure that a written record is kept of the results of the annual evaluation and of any changes that were implemented.

The Administrator was not able to provide the written record for 2014, of the results of the annual evaluation and of any changes that were implemented.

The Administrator was not able to provide the inspectors the 2015, written record of the results of the annual evaluation and of any changes that were implemented.

When asked of the licensee if they had any other records of the 2014 and 2015 annual evaluations of the effectiveness of the medication management system in the home, the Administrator said during an interview on November 17, 2016, that they provided what records they could.

The home failed to ensure that a written record was kept of the results of the annual evaluation and of any changes that were implemented for the medication management program.

The severity of this non-compliance was minimal harm and the scope was widespread. The home does not have a history of non-compliance in this subsection of the legislation.

***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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietician who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.***

---

**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 123. Emergency drug supply**
**Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,**
**(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;**
**(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;**
**(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and**
**(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.**

**Findings/Faits saillants :**

The licensee has failed to ensure that b) a written policy was in place to address the location ofthe emergency drug supply; and c) that at least annually there was an evaluation done by the Medical Director, in collaboration with the pharmacy service provider, Director of Nursing and Personal Care and the Administrator, of the utilization

of drugs kept in the emergency drug supply in order to determine the need for the drugs; and d) that any recommended changes resulting from the evaluation were implemented.

During the inspection, inspectors completed observations of the medication rooms, medication carts, medication administration, drug destruction of controlled substances and non- controlled drug substance destruction, documentation related to signage of ordering and receiving medication from the pharmacy, documentation for medication administration on the EMAR, signage of controlled substances by the registered staff and identified areas of risk with findings of non- compliance.

Further review of the licensee's annual evaluation on the medication management programs showed that the licensee had not completed the review for 2014 and 2015, and that the audit procedures had not been conducted, implemented or evaluated.

Interviews were conducted in the home with the Administrator, DOC, Pharmacy Consultant and registered staff. The interviews showed that the policies and procedures related to the management of the medication program were not clearly understood.

Review of Professional Advisory Committee (PAC) meeting minutes from January 24, 2013, showed that the Medical Director, Pharmacist, and DOC completed the annual review with an evaluation of the emergency drug box supply for the home. There was no documentation to show that an evaluation of the emergency drug box supply for the home was completed in 2014 and 2015.

A review of The Silver Fox Pharmacy Policy for Emergency Medication Home Supply 3.10 states that:

*Silver Fox Pharmacy along with Medical Director, the Administrator and the Director of Care for thehome will review the medication requested for the emergency medication supply on an annual basis.

The licensee policy for Resident Rights, Care, and Services: Medication Management Evaluations of Pharmacy Services revised 2013-10-07 states that,
the Administrator will:

Seek input from the multidisciplinary team to determine the level of satisfaction with the provision of services by the contracted pharmacy vendor.

Arrange a meeting with the contracted pharmacy vendor to discuss input received from the multidisciplinary team provide feedback relative to the provisions of pharmacy services within the home, identify effectiveness of the services provided and efforts made to improve services.

Document the outcomes of the meeting in written communication to the contracted pharmacy vendor.

Provide a report to the Pharmacy and Therapeutics Committee summarizing the outcomes of the above.

The licensee and Silver Fox Pharmacy policies failed to address the location of the emergency medication home supply. In an interview with the Administrator they acknowledged that the emergency drug supply location was not addressed.

The licensee failed to ensure there was an annual evaluation of the emergency drug supply for the home, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs for 2014 and 2015 completed by the Medical Director, pharmacy service provider, DONPC and Administrator.

The severity of this non-compliance was minimal harm and the scope was widespread. The home does not have a history of non-compliance in this subsection of the legislation.

***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 there is a written policy in place to address the location of the emergency drug supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply, that, at least annually, there is an evaluation done by the Medical Director in collaboration with the Pharmacy Service Provider, the Director of Nursing and Personal Care and the Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and that any recommended changes resulting from the evaluation are implemented, to be implemented voluntarily.***

---

**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes**
**Every licensee of a long-term care home shall ensure that,**
**(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;**
**(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and**
**(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.**

**Findings/Faits saillants :**

The licensee failed to ensure that appropriate actions were taken when a resident is taking anydrug or combination of drugs, including psychotropic drugs, that there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risklevel of the drugs.

During the inspection, inspectors reviewed the licensee's and the pharmacy service provider's current policies, that are utilized by the licensee, drug records related to ordering and receiving of medication, and the eMAR. The inspectors also interviewed staff of the licensee and representatives of the pharmacy service provider.

During the inspection, inspectors completed observations of the medication rooms, medication carts, medication administration, drug destruction of controlled and non-controlled substances, documentation related to signage of ordering and receiving medication from pharmacy, documentation for medication administration on the eMAR, and signage of controlled substances by the registered staff. From the record reviews, interviews, and observations, non-compliance with the following requirements was identified.

An identified resident had a significant change in health status and was transferred to hospital and deceased in hospital six days later.

On a specific date, a registered staff member administered a medication to the resident that was to be given. According to the electronic medication administration record (eMAR) the medication was provided at a specific time. Further review of the documentation in PCC and the eMAR shows the RN who provided this medication to the resident did not document the reason that the required controlled substance was administered, the effectiveness of the medication provided, or an assessment of the resident.

Two hours and seventeen minutes later, the eMAR, shows the same registered staff member further administered to the resident a specific medication to be given as needed and a controlled narcotic given as needed. There was no documented reason for the required controlled substance to be administered, the effectiveness of the medication provided, or an assessment of the resident.

On a specific date and time the same registered staff member administered a controlled substance to the identified resident.
The licensee policy Administration of Medication, revised 2015-07-14 says in part that:

When the nurse assesses a resident and deems that an as needed (PRN) medication would benefit the resident as per the physician orders, the nurse will document the effect of the PRN medication as per the home's specific policy; document the actions taken and follow up actions to be taken in the progress notes.

Further review of Point Click Care progress notes on a specific date, shows that a registered nurse assessed the identified resident and three progress notes were documented over a three hour period that showed a decline in the resident's health condition. The resident was transferred to the hospital.

Inspector #610 requested the identified resident's heath care records for the individual controlled narcotic records. The Administrator said that they could not provide the records for the individual narcotic sheets for the administration of the controlled narcotic records for the resident as they were not kept.

The previous Administrator, Director of Care and Co-Director of Care all said that they were not aware of the medications administered to the identified resident by the registered staff member prior to the resident being transferred to the hospital.

The licensee failed to ensure that appropriate actions were taken when the resident was taking any drug or combination of drugs, including psychotropic drugs, that there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The severity of this non-compliance was minimal harm and the scope was isolated. The home does not have a history of non-compliance in this subsection of the legislation

***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 appropriate actions were taken when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.***

**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system**

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

**s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).**

**Findings/Faits saillants :**

The following is the evidence used and further evidence to support compliance Order #901 issued in this inspection with a Compliance Date of April 6, 2017.

1. The licensee has failed to ensure the written policies and protocols related to the medication management system were developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. O. Reg.79/10, s. 114 (3)(a).

During the inspection, inspectors reviewed current policies of both the licensee and pharmacy service provider that are being utilized by the licensee, documentation of drug records related to ordering and receiving medication, and the electronic Medication Administration Records e(MAR). Staff of both the licensee and representatives of the pharmacy service provider were interviewed.

The licensee utilizes the pharmacy service provider Classic Care Pharmacy policy titled "Administering and Documenting Controlled Substances" revised July 2014, states in part:

*An audit of the daily controlled substances count sheet is to be completed by the staff at the home on a monthly basis.

*All discrepancies must be reported immediately to the Director of Care.

*Each dose of every controlled substance is accounted for on an individual narcotic sheet. The controlled substance is documented recording the date and time, quantity administered, quantity remaining, and signature of the person administering.

The licensee also has a policy developed for the management of narcotics and controlled substances. The licensee's current policy titled "Medication Management Narcotics and Controlled Substances" with a revised date of 2013-10-07, states in part:

*A count of narcotics shall be completed by the off going and incoming registered staff member at change of shift and whenever an exchange of medication keys takes place.

*All Narcotic counts shall be documented in permanent ball point ink.

A) Review of the home's Narcotic and Controlled Medication Audits completed by Classic Care Pharmacy Service Pharmacy Manager includes:

* On a specific date on one home area, "Monthly audits of daily controlled narcotic and controlled substance count sheets needs to be completed by the home."

* On a specific date on one home area, "Remind the nurses to sign the narcotic count sheets after every sheet. Three daily shift counts were identified as not being completed by two registered nursing staff in the home."

A review of an identified resident's individual controlled narcotic record for a specific medication over a one month period, showed that on five separate days, staff did not document each time the controlled substance was administrated. Count records of the medication were not accurately counted for, or signed for, and the documentation in part was illegible and not completed. On five separate occasions, the documentation showed the word "found" for medication discrepancy in the count record as staff was not signing for the controlled substance on the individual controlled substance record once it was administered. Nursing staff did not always provide a full signature or initials after administering the medication or their professional designation as per the Nursing Best Practices guidance documentation from the College of Nurses of Ontario.

B) A review of the home's General System Audits completed by Classic Care Pharmacy Service Manager for one home area found "Missing signatures for a specific time on the count sheets" on a specific date.

A review of the home's "Narcotic, Controlled, and Targeted Ward Count" record sheets over a one month period, for one home area, showed information documented on the record sheets that had been scratched out and written over in ink, including dates,

narcotic counts, and times given. The narcotic shift counts did not include signatures by two registered staff with designation for every shift.

The registered staff has failed to complete the signage on both the Controlled Substance Shift Count sheets and the individual Controlled Narcotic Count sheets for the administered medication of residents.

During an interview the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each shift when completing the narcotic count. The DOC also said that the home has not been completing the monthly audits.

C) The inspector requested the licensee produce the individual controlled narcotic record sheets for two of the identified resident's medication that had been administered over a one month period. The Administrator told the inspector that the requested records could not be found as those records had not been kept.

The counting and verifying of controlled substances after controlled medication was administered to the resident was not completed by staff at the time of administration and by two staff at every shift change as required by the licensee's policy.

The licensee failed to ensure that the pharmacy's policy on the management of narcotics and controlled substances which is based on evidence-based and prevailing practices and that the policy of the licensee was implemented as two staff had not counted, verified and documented on the count sheets for controlled substances at every shift change. Staff had not signed off on the individual narcotic substance narcotic sheets after administration of a controlled substance and audits of the controlled narcotic system were not done.

2. Interviews were conducted in the home. Responses to questions posed to the Administrator, Director of Care (DOC), Silver Fox Pharmacy Consultant and registered staff in the home and the inspectors' observations showed that the policies and procedures related to the management of the medication program were not clearly understood by staff interviewed, and not implemented in a consistent manner by all staff.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that Silver Fox Pharmacy's policy on the drug destruction of controlled substances was a recommendation to the licensee. However, the Administrator told the inspectors that the medication management program policies and procedures developed by Silver Fox

Pharmacy are the policies and procedures for the home. The Administrator also said that the licensee expected that staff would follow Silver Fox Pharmacy's policies and procedures, and that staff had been trained and told to follow Silver Fox Pharmacy's policies and procedures. This training was provided to registered staff by Silver Fox Pharmacy on specified dates in 2016. Despite this, the licensee has a number of other policies and procedures that were developed by the licensee related to the management of the home's medication program that are currently in force and available to all staff.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that the Silver Fox Pharmacy has been a service provider in long-term care homes since June, 2016. The Pharmacy Consultant said that the policies and procedures provided by Silver Fox Pharmacy have been developed, implemented, evaluated, and updated in accordance with evidence best practices, and if there were none in accordance with prevailing practices, and that the policy and procedures provided by Silver Fox Pharmacy are based on requirements in the Long-Term Care Homes Act, 2007, and that they are based on prevailing practices from the College of Nurses of Ontario, and the Ontario College of Pharmacists.

A. Silver Fox Pharmacy's policy on the disposal and destruction of non-controlled substances that is based on evidence-based and prevailing practices and that is utilized by the licensee was not implemented.

The Licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Disposal of Non-Controlled Medication", Policy 5.6, dated June 2016 as the policy of the home. Silver Fox Pharmacy Consultant told the inspectors that this policy is based on prevailing practices within the industry. This policy states in part:

*The following medications should be placed in buckets, transdermal patches, medications removed from the blister packets and med strips. Inhalers, liquid, nasal, eye and ear preparations are opened and dumped. Vials, cartridges, and ampules are opened and emptied. Creams and ointments are opened and dumped.

*An annual schedule of medication destruction pick up dates was provided to the homes at the beginning of each calendar year.

*Medications awaiting destruction must be stored in a secure, designated area within the home, separate from medications that were to be administered to the residents.

*The Medication Destruction Form should be signed and dated by both of the staff members who participated in the medication destruction.

*The Medication Destruction Form must be retained in the home by the Director of Care for a minimum of 2 years.

The licensee also utilized Silver Fox Pharmacy's policy titled "Safe Storage of Medication" Policy 5.1 dated June 2016. Silver Fox Pharmacy Consultant told the inspectors that this policy is based on prevailing practices within the industry. This policy states in part that:

* Unused or wasted medication should be stored away from active medication in a locked area until it can be returned to Silver Fox Pharmacy.

The licensee also has a policy that it developed for drug disposal. The licensee's current policy titled "Residents Rights, Care and Services, Medication Management, Drug Disposal" with a revised date of 2013-10-07 states in part:

*All medications which are discontinued, unused, expired, recalled, deteriorated, unlabelled and in containers with worn, illegible, damaged, incomplete or missing labels shall be removed from general stock and stored in a safe and secure system awaiting drug destruction. Drug disposal shall be documented on the Surplus Prescribed Drug Form after destruction has occurred.

*The Surplus Prescribed Drug Form will be completed in full detailing the following information: date of destruction or removal of the drug, prescription number of the drug, Pharmacy name, resident's name, drug name, strength and quantity, reason for destruction or removal.

*The Director of Care will retain a copy of the Surplus Prescribed Drug Form for a two (2) year period.

The licensee's current policy titled "Residents Rights, Care and Services "Medication Management Drug Disposal" is not the same as Silver Fox Pharmacy's policy titled "Documentation and Storage of Medications Disposal of Non-Controlled Medications".

During an interview, Silver Fox Pharmacy Consultant told the inspectors that according to

its drug destruction policy, the non-controlled substances were to be denatured to an extent where consumption or use was improbable; and that all drug components and anything considered a medication would be going into the buckets for destruction even though syringes were not something recommended to be placed in these buckets.

Inspectors observed the medication rooms and medication carts of the four home medication storage areas and noted the following:

In one medication cart there was one specific medication with a pharmacy label that was illegible, and did not have any resident identifying information. In one medication cart there was one specific medication with a pharmacy label that was illegible and damaged, and a second medication label that was illegible, and had incomplete information. As a result, it was not possible to identify which resident these medications were prescribed to.

In the top drawer of one medication cart, there was a specific medication, which had an expiry date. In one medication cart, there was a specific medication, which had an expiry date.

Underneath one medication room sink there was a white bucket being used as a drug destruction container labelled "MPLN BLUE" and inside the bucket there was disposed pills, inhalers, glass vials, insulin cartridges, and a syringe. The lid to the white bucket was not securely fastened and the inspectors were able to remove the lid from the bucket. Resident personal health information (PHI) was found in this bucket with disposed medication.

Underneath one medication room sink, the inspectors found medications (including expired medications that had not been administered to residents on the date and time as per the directions from the prescriber), that were opened and left in medication cups, as well as unopened resident strip medication packages.

In one medication room there was medication in a brown box on the floor next to several white garbage bags that contained residents' medication packages with the residents' PHI.

In one medication room there was a white bucket being used as a drug destruction container, and inside the bucket there were resident identifiers, and the lid to the bucket was not securely fastened as the inspectors were able to remove the lid from the bucket.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home showed that audits were completed by Silver Fox Pharmacy for a three months period in 2016. The audits identified, among other things, that the licensee had not ensured the Silver Fox Pharmacy's policies and procedures were followed and implemented for medication drug destruction for non-controlled drug-substances, and that medication audits of carts had not been completed to ensure the removal of expired medication.

The Director of Care said that Silver Fox Pharmacy had brought to her attention that the drug destruction records were not being kept or completed correctly by the registered staff for destruction of non-controlled drug substances.

During an interview, the Administrator acknowledged to the inspectors that the licensee's expectation was that all unlabeled or expired medications, or containers with worn, illegible, damaged, incomplete or missing labels would be destroyed and replaced. The Administrator stated that the drug destruction of medications would be completed per the policy of the home, and that syringes would be disposed of in a sharps container. The Administrator acknowledged that the licensee should have been following Silver Fox Pharmacy's policy and procedure for the medication destruction of non-controlled drug substances and had not.

The licensee failed to ensure that Silver Fox Pharmacy's policy on the disposal and destruction of non-controlled substances that is based on evidence-based and prevailing practices, was implemented as medications were not put in buckets, medications awaiting destruction were not stored in a secure, designated area within the home, separate from medications to be administered to residents, and unused or wasted medication was not stored away from active medication.

B. Silver Fox Pharmacy's policy on the management of narcotics and controlled substances which is based on evidence-based practices and prevailing practices, and utilized by the licensee, was not implemented.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016 as the policy of the home. Silver Fox Pharmacy Consultant #109 told the inspectors that this policy is based on prevailing practices within the industry.  This policy states in part that counts must be done at every

shift change with two staff members on the Controlled Substance Shift Count Record. Both staff members must be present and complete the count together.

An audit of the daily controlled substances count sheet is to be completed by the staff at the home on a monthly basis. All discrepancies must be reported immediately to the Director of Care.

The licensee also has a policy that it developed for the management of narcotics and controlled substances. The licensee's current policy titled "Medication Management Narcotics and Controlled Substances" with a revised date of 2013-10-07 states in part:

A count of narcotics shall be completed by the off going and incoming registered staff member at change of shift and whenever an exchange of medication keys takes place. All Narcotic counts shall be documented in permanent ball point ink.

The licensee's current policy titled "Medication Management Narcotics and Controlled Substances" is not the same as Silver Fox Pharmacy's policy titled "Documentation and Storage of Medication Controlled Substance Documentation".

A review of the Controlled Substance Shift Count sheets provided by Silver Fox Pharmacy with a date range of October 24, 2016 to November 11, 2016, showed that on October 24, 25, 26, 27, and 30, and November 2, 3, 4, and 6, 2016, that two staff had not counted and verified the controlled substances of every shift. On these specified dates, registered staff had failed to complete the signage on the Controlled Substance Shift Count sheets. The counting and verifying by two staff of controlled substances at every shift change was not completed as required by Silver Fox Pharmacy's policy, which is the policy of the home.

During an interview, the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each shift when completing the narcotic count.

The Silver Fox Pharmacy Consultant said that they provide education to staff as well as all documents for drug record or administration of controlled substances. But if that didn't happen, their role as the pharmacy service provider in relation to the medication management system as a whole, is to notify management and try to coordinate a plan to minimize the recurrence of any errors.

The Staff Educator said that the registered nursing staff received education related to Silver Fox Pharmacy's policies and procedures on August 22 and 23, 2016.

The licensee failed to ensure that Silver Fox Pharmacy's policy on the management of narcotics and controlled substances that is based on evidence-based and prevailing practices and that is utilized by the licensee was implemented as two staff had not counted, verified and documented on the count sheets for controlled substances at every shift change.

3.The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, or (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122(1).

On a specific date and time, the inspectors observed one medication room and medication cart and noted that in the locked box in the medication cart there were two bottles of a specific medication. Neither bottle of medication had labels or packaging information provided by the pharmacy. Instead, the two bottles had a piece of tape on the lid on which the resident's first name and quantity of medication were hand written.

During an interview, Silver Fox Pharmacy Consultant was shown pictures of the two bottles of a specific medication. Silver Fox Pharmacy Consultant stated that they did not believe those bottles were provided by Silver Fox Pharmacy and that they understood, according to the Act, that medications only came from the pharmacy service provider or the Government of Ontario Pharmacy.

During an interview, DOC told the inspectors, when asked about the labelling on the medication bottles, that the home does not receive medications from Silver Fox Pharmacy without labelling.

The licensee failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident unless the drug (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, or (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario Pharmacy.

The licensee has failed to ensure that drugs remain in the original labelled container or

package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

On a specific date and time, inspectors #610 and #658 observed the medication cart in one medication room and noted that there were medications in medication cups for three residents in the fourth drawer. As the medications were in medication cups, they were not in the original labelled package provided by the pharmacy. The only information identifying the medications, was the top of the strip packages provided by the pharmacy including: the resident's name, and date and time of administration which was for specific time on a specific date. There was no identifying information connecting the resident to the medications in the cups to identify who was to receive the medications. As a result, the medications were in the medication cups for approximately 2.5 hours and not in their original labelled packaging provided by the pharmacy.

On a specific date, the inspectors observed one medication cart and noted that there was one medication with a pharmacy label that was illegible and damaged, and also a second medication label that was illegible and had incomplete information. It was not possible to identify which residents these medications were prescribed for.

On a specific date and time, the inspectors observed one medication room and medication cart and noted the following:

There was one medication with a pharmacy label that was illegible and did not have any resident identifying information. There was also a medication with a Silver Fox Pharmacy label that was worn off and the resident's name and "NR"were hand-written with ink. It was not possible to identify which residents these medications were prescribed for.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Safe Storage of Medication" Policy 5.1 dated June 2016. This policy states in part:

*All medication should remain in the original Silver Fox container until they are administered to an individual; and unused or wasted medication should be stored away from active medication in a locked area until it can be returned to Silver Fox Pharmacy.

The licensee also has a policy that it developed pertaining to the packaging and labelling of medications. The licensee's current Policy titled "Administration of Medications" with a revised date of 2015-07-24 states in part:

*Administer medication only from properly labelled vials, packages, strip pouches, and blister packs dispensed from pharmacy.

During an interview, Silver Fox Pharmacy Consultant said that the expectation of labelling and packaging of medications was that anything that came from the pharmacy service provider would not be altered, and that if a medication had an illegible label, the medication would be removed and would not be used for administration.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home showed that audits were completed by Silver Fox Pharmacy for the months of September, November, and December 2016. The audits identified, among other things, that labelling of insulin cartridges and medication did not have the pharmacy labels for resident identifiers and prescribed orders.

During an interview, the Administrator acknowledged that missing or illegible labels should be replaced on unlabeled and expired medications, or on containers with worn, illegible, damaged, incomplete, or missing labels.

The licensee failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

4.The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1)(b).

On a specific date and time, the inspectors observed the medication room and medication cart for one home area. The inspectors observed controlled substances within the locked medication cart in the fourth drawer with non-controlled medications. Specifically, the inspectors observed controlled substances: ampules left in a medication cup that had been opened and used for a resident, with a clear substance remaining in both ampules. Upon further review, the medication cart contained a separate locked area in the bottom drawer but these controlled substances were not in that separate locked area.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016. This policy states in part that:

*Every controlled substance in the home must be stored separately from other items and must be double locked.

*The licensee's current policy titled "Medication Management-Drug Storage" with a revised date of 2013-10-07 states in part that:

*Staff are to ensure that all narcotics are stored in a double locked, permanently affixed compartment within the general medication cart and or medication room.

On a specific date, due to the immediate risk presented by the opened and unsecured medication, the inspectors asked the Administrator to observe the controlled substances that were in the fourth drawer of the medication cart. The Administrator observed the fourth drawer of the medication cart and told the inspectors that the opened and unsecured medication were not stored in accordance with the licensee's policy on the storage of narcotics.

After the inspectors brought the unsecured medication to the attention of the Administrator, a medication incident report was completed.

During an interview, a registered staff member told the inspectors that they completed a medication incident report, regarding the opened and unsecured controlled narcotic medications ampules that were observed by the inspectors. The registered staff member said that the process for using and discarding a controlled substance was to:

*Withdraw the amount required for the resident; Leave any remaining unused medication in the ampule; Co-sign with the second nurse; and Discard the ampule with the unused medication into the sharps container.

The medication incident report related to the inspector's observation showed that the identified staff member received re-education on the licensee's drug disposal policy, a quiz on the medication practice standard from the College of Nurses of Ontario, and a written warning from the Director of Care.

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

5.The licensee has failed to ensure that steps were taken to ensure the security of the

drug supply, including that a monthly audit was 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. O. Reg. 79/10, s.130. 3.

Silver Fox Pharmacy completed its own audits for September, November, and December, 2016, regarding the medication management system in the home. These audits showed that the licensee had not completed audits of the daily count sheets for controlled substances to verify counts and to resolve any discrepancies immediately.

During an interview, the DOC told inspector #658 that they have a tool to audit the controlled substances, that this audit process was the responsibility of the DOC, and had not been implemented.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016. This policy states in part:

*Counts must be done at every shift change with two staff members on the Controlled Substance Shift Count Record. Both staff members must be present and complete the count together.

*An audit of the daily controlled substances count sheet is to be completed by the staff at the home on a monthly basis. All discrepancies must be reported immediately to the Director of Care.

The DOC told the inspectors that the licensee had not completed monthly audits of the controlled substances as per the home's policy for August 2016, to January 12, 2017, and that the licensee's expectation is that monthly audits are completed and that any discrepancies are addressed immediately.

During an interview, the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each narcotic count and completed at every shift change.

A review of the Controlled Substance Shift Count sheets provided by Silver Fox Pharmacy with a date range of October 24, 2016 to November 11, 2016, showed that on October 24, 25, 26, 27, and 30, and November 2, 3, 4, and 6, 2016, that two staff had not counted and verified the controlled substances on every shift. On these specified dates,

registered staff had not signed the Controlled Substance Shift Count sheets.

In an interview with the DOC, they said they were aware of the results of the missing signatures on the controlled substance records by the pharmacy audits and staff informing them.

The licensee failed to ensure that a monthly audit was 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.

6.The licensee has failed to ensure that no drug was administered to residents unless the drug was prescribed for the resident. O. Reg. 79/10, s. 131 (1)

A Controlled Substance Administration Record for an identified resident was reviewed in one of the medication rooms. The record showed that the resident received a specific controlled substance every four hours as needed. Record review of a second identified resident indicated that they had an order for a specific controlled substance every six hours as needed. The Controlled Substance Administration Record for the first resident indicated that the same medication that was ordered, purchased, and prescribed for the resident was borrowed and administered to the second resident four times in two days.

The Controlled Substance Administration Record for the second resident showed that on a specific date, the resident was given one dose of the controlled substance, and on the next day, three more doses of the controlled substance were administered to the resident from the first resident's medication card.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that if staff ran out of medications, they would access the emergency drug supply first, and then contact the on-call pharmacist. Silver Fox Pharmacy Consultant further explained that borrowing medication (giving a resident the medication that was prescribed for another resident) was not a practice they recommended and that the medication for the second resident should have been reordered as required. The Silver Fox Pharmacy Emergency Pharmacy Procedures Policy 3.9 states:

*Silver Fox Pharmacy provided 24/7/365 emergency medication service outside of their business hours.

The licensee's current policy titled "Administration of Medication" with a revised date of

2015-07-24 states in part that staff are to: "Apply the "rights" of medication administration, including the right resident".

During an interview, the DOC told the inspectors that the licensee's expectation was that residents would only be administered medications that were ordered and prescribed for that resident, and dispensed to that resident by the home's pharmacy service provider.

The licensee failed to ensure that the identified resident was only administered medication that was prescribed for them.

7.The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse or a nursing student O. Reg. 79/10, s. 131 (3)

On a specific date and approximate time, a registered staff member was observed pouring an identified medication that was prescribed for an identified resident. The registered staff member proceeded to the dining room and gave the identified medication to a non-registered nursing staff member. The registered staff member then walked back to the medication cart, and the inspectors observed the PSW administer the medication to the resident.

The licensee's current policy titled "Medication Administration Record", with a revised date of 2015-07-24 states:

"All medications shall be administered only by those authorized under the Health Professionals Act and their respective regulatory colleges".

The registered staff member told the inspectors that the identified medication was on the eMAR and registered staff signed for the identified medication as prescribed for the resident.

The Administrator told the inspectors that their understanding was that whoever poured the medication administered the medication, and acknowledged that the identified medication was a medication that should not be administered by PSW's.

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered a practical nurse.

8.The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded, in respect of every drug that was ordered and received in the home:

1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

On a specific date, the inspectors reviewed the drug record book in one medication room, which showed that an identified resident had a controlled substance re-ordered for them on a specific date. The medication was received for the resident on a specific date per the medication label on the medication card in the controlled medication bin in the medication cart. The resident was administered the medication the following seven days after being received. For this medication received for the identified resident, the drug record book did not include the prescription number, the quantity of tablets, or the signature of the person acknowledging receipt of the drug on behalf of the home.

The inspectors reviewed the drug record book in one home area with a date range from October 1 to October 31, 2016. The drug record book showed that a total of 122 drug re-orders were made during this time period. 116 of the 122 drug re-orders were not completed in their entirety as the drug record for each of these 116 re-orders did not show the quantity of the drug that was ordered, the prescription number for the drug that was ordered, the date the drug was received in the home, or the signature of the person acknowledging receipt of the drug on behalf of the home.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Drug Record" Policy 3.3 dated June 2016. This policy states in part:

The Drug Record (DR) was intended to be a record of all medications that were ordered and received by the home. Once the new or repeated medication had been received at

the home, the person checking it in will sign, date, record the new prescription number and the quantity received. Any staff member may check the DR to verify that the medication had been received within the home.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home for audits that were completed by Silver Fox Pharmacy for the months of September, November, and December 2016 identified, among other things, that the drug record book was not being maintained and drug records were not kept, and that the drug record book was not being signed properly for ordering and re-ordering and receiving of medication by staff.

The Administrator told the inspectors that when the medication was delivered to the home from the pharmacy, it was the expectation that staff would be signing in the delivered medications in the drug record book.

The licensee failed to ensure that the following information was recorded in the drug record in respect of every drug that was ordered and received in the home, in accordance with O. Reg. 79/10, s. 133:

3. The quantity of the drug;
6. The prescription number;
7. The date the drug was received in the home; and
8. The signature of the person acknowledging receipt of the drug on behalf of the home.

9.The licensee failed to ensure that a plan, policy, protocol, procedure, strategy or system that is required by the Long-Term Care Homes Act, 2007 or O.Reg. 79/10 was complied with. O.Reg. 79/10, s. 8(1) (b).

The licensee is required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(4) states that the written drug destruction and disposal policy must provide that where a drug that was to be destroyed was a controlled substance, the applicable team members document the following in the drug record: the date of removal of the drug from the drug storage area; the name of the resident for whom the drug was prescribed, where applicable; the prescription number of the drug, where applicable; the drug's name, strength and quantity; the reason for destruction; the date when the drug was destroyed; the names of the persons who destroyed the drug; and the manner of destruction of the drug.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Disposal of Controlled Medications" Policy 5.7 dated June 2016. This policy states in part:

*With two registered staff members present, the remaining quantity of medication is circled on the controlled substance administration record and documented in the appropriate space. A diagonal line should be drawn through the remaining spaces on the count sheet space; the reason for the destruction should be documented on the count sheet. The form is to then be signed in the appropriate space by two registered staff.

The inspectors reviewed the controlled substance administration records for five residents with dates ranging from September to October, 2016, and identified that all of the sheets were incomplete. Review of all five residents' controlled substance administration records showed that the reason for the drug destruction, the two registered staff signatures signed for when controlled substances were removed, the quantity removed, and the removal dates were not documented. Four out of the five controlled substance administration records did not have the remaining quantity of the medication circled, and two of the five records did not have a diagonal line drawn through the remaining spaces as directed by Silver Fox Pharmacy's policy.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that they believed that staff were educated on how to use the controlled substance administration record for destruction and that it would have been covered during the education provided by Silver Fox Pharmacy to registered staff in the home on August 22 and 23, 2016.

During an interview, the Administrator told the inspectors that it was an expectation that the home would be following the policy from Silver Fox Pharmacy related to drug destruction of a controlled substance.

The licensee failed to comply with the drug destruction and disposal policy required by O. Reg 79/10, s. 136(1) by failing to ensure that where a controlled substance was destroyed the applicable team members documented the information required by s. O. Reg. 79/10, s. 136(4).

10.The licensee failed to comply with O. Reg. 79/10, s. 134(b), ensuring that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

An identified resident's pain assessment in PCC completed on admission, showed that the resident was receiving pain medication for specific diagnoses.

Review of the eMAR showed that the resident was to receive pain medication twice a day at specific times.

On a specific date, the progress notes for the resident created by a registered staff member showed that the resident had not received their pain medication at both specific time as prescribed.

Further review of the eMAR and PCC showed that there was no further action taken to respond to the omission of medication, and the resident had not been reassessed for pain management.

During an interview, the registered staff member told the inspectors that they did not give the medication to the resident as prescribed, had not completed a medication incident report and that there was no further action taken to assess the resident's pain as a result of the omission of medication.

The DOC told the inspectors that they were not aware of the medication incident for the identified resident and that a medication incident report should have been completed and had not been completed.

The licensee failed to ensure that appropriate actions were taken in response to the medication incident involving the identified resident.

The Severity of Risk was potential for risk or risk for actual harm and the scope was widespread. There was previous compliance history O. Reg. 79/10, s. 129 issued on April 2, 2014, a Written Notification was received; O. Reg. 79/10, s. 131 (3) issued on January 24, 2014, a Written Notification and Voluntary Plan of Correction was received; and O. Reg. 79/10, s. 8(1) (b) issued on February 9, 2016, February 3, 2015, April 16, 2015, and May 24, 2014 a Written Notification and Voluntary Plan of Correction was received.

---

**Issued on this 17th day of August, 2017**

| 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) :** | Natalie Moroney (610), Neil Kikuta (658), Rhonda Kukoly (213) |
| **Inspection No. / No de l'inspection :** | 2016_254610_0033 |
| **Log No. / Registre no :** | 029630-16 |
| **Type of Inspection / Genre d'inspection :** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Feb 6, Aug 15, 2017 |
| **Licensee / Titulaire de permis :** | MEADOW PARK (LONDON) INC<br>689 YOUNG STREET, MIDLAND, ON, L4R-281 |
| **LTC Home / Foyer de SLD :** | MEADOW PARK (LONDON) INC<br>1210 SOUTHDALE ROAD EAST, LONDON, ON, N6E-1B4 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Nicole Ross |

To MEADOW PARK (LONDON) INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 901

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

## Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

**Order / Ordre :**

To achieve compliance with O. Reg. 79/10, s. 114 (1), the licensee shall develop an interdisciplinary medication management system that provides safe medication management O. Reg. 79/10, s. 114 (1). The licensee is also required to:

1. Educate and train all registered staff on safe storage of controlled substances in double locked storage areas or in a separate locked area within the locked medication cart.

2. Educate and train all registered staff that drugs must remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

3. Educate all registered staff regarding the policy and procedures for unused or wasted medication for storage; and implement the procedure on administering medications from properly labelled vials, packages, strip pouches, and blister packs dispensed from the home's pharmacy service provider.

4. Develop a procedure to ensure expired medications are removed from the medication carts. Evaluate the implementation of the procedure to ensure it is followed by all registered staff.

5. Educate and train all staff to ensure that only staff that are authorized to administer medications fulfill that function.

6. Educate and train all registered staff regarding the policy and procedure for maintaining a drug record.

7. Implement a system for establishing accurate and up-to-date drug records that include the following information for every drug that is ordered and received in the home:
a. documentation for every drug that is ordered and received in the home;
b. the signature of the person placing the order;
c. the name, strength and quantity of the drug;
d. the name of the place from which the drug is ordered;
e. the name of the resident for whom the drug is prescribed, where applicable;
f. the prescription number, where applicable;
g. the date the drug is received in the home; and
h. the signature of the person acknowledging receipt of the drug on behalf of the home.

Maintain and keep a drug record for every drug that is ordered and received in the home within the home for at least two years.

8. Educate and train all registered staff on the procedure in the home for the recording of the daily count sheets for controlled substances.

9. Conduct monthly audits of the daily count sheets for controlled substances. Evaluate the information gathered through the monthly audits to determine if there are any discrepancies and take immediate action if any discrepancies are discovered. Document the actions taken.

10. Educate and train all staff on the licensee's policy and the legislative requirements for drug destruction of a controlled substance. This education will include training for all registered staff with respect to the licensee's drug destruction and disposal policy and how to complete the documentation record to ensure the following information is documented: the date of removal of the drug from the drug storage area; the name of the resident for whom the drug was prescribed; the prescription number of the drug, the drug's name, strength and quantity, the reason for destruction; the date when the drug was destroyed; the names of the members of the team who destroyed the drug and the manner of destruction of the drug.

11. Educate and train all registered staff on the policies and procedures for ordering, re-ordering, and receiving all medication for residents.

12. Implement the licensee's policy on Administration of Medication and conduct audits at least monthly to ensure that medication that is ordered and prescribed for a resident is administered to that resident only.

13. Educate and train all registered staff on the medication incident reporting system, including what needs to be reported and documented, when and to whom reporting must be done, and the actions to be taken when a medication incident is identified.

14. Develop and implement a system to ensure that an evaluation is conducted of all medication incidents and that appropriate actions are taken when concerns are identified.

**Grounds / Motifs :**

The Severity of Risk was potential for risk or risk for actual harm and the scope was widespread. There was previous compliance history:

• O. Reg. 79/10, s. 129 issued on April 2, 2014, a Written Notification was received;
• O. Reg. 79/10, s. 131 (3) issued on January 24, 2014, a Written Notification and Voluntary Plan of Correction was received; and
• O. Reg. 79/10, s. 8(1) (b) issued on February 9, 2016, February 3, 2015, April 16, 2015, and May 24, 2014 a Written Notification and Voluntary Plan of Correction was received.

The licensee of the long-term care home failed to develop an interdisciplinary medication management system that provided safe medication management, as evidenced by:

1. The licensee failed to comply with O. Reg. 79/10, s. 114(3)(a), by failing to ensure that written policies and protocols were developed, implemented, evaluated and updated in accordance with evidence

based practices and, if there were none, in accordance with prevailing practices.

2. The licensee failed to comply with O. Reg. 79/10, s. 122(1), by failing to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, or (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario.

3. The licensee failed to comply with O. Reg. 79/10, s.126, by failing to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

4. The licensee failed to comply with O. Reg. 79/10, s 129 (1) (b), by failing 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.

5. The licensee failed to comply with O. Reg. 79/10, s. 130 (3), by failing to ensure that a monthly audit was 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.

6. The licensee failed to comply with O. Reg. 79/10, s. 131 (1), by failing to ensure that no drug was administered to residents unless the drug was prescribed for the resident.

7. The licensee failed to comply with O. Reg. 79/10, s. 131 (3), by failing to ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse, a registered practical nurse or a nursing student.

8. The licensee failed to comply with O. Reg. 79/10, s. 133, by failing to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information in respect of every drug that was ordered and received in the home:
   1. The date the drug was ordered
   2. The signature of the person placing the order
   3. The name, strength and quantity of the drug
   4. The name of the place from which the drug was ordered
   5. The name of the resident for whom the drug was prescribed, where applicable
   6. The prescription number, where applicable
   7. The date the drug was received in the home
   8. The signature of the person acknowledging receipt of the drug on behalf of the home
   9. Where applicable, the information required under subsection 136(4).

9. The licensee failed to comply with O. Reg. 79/10, s. 8(1)(b), by failing to ensure that a plan, policy, protocol, procedure, strategy or system that is required by the Long-Term Care Homes Act, 2007 or O.Reg. 79/10, was complied with.

10. The licensee failed to comply with O. Reg. 79/10, s. 134(b), by failing to ensure that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

1. Interviews were conducted in the home. Responses to questions posed to the Administrator, Director of Care (DOC), Silver Fox Pharmacy Consultant and registered staff in the home and the inspectors' observations showed that the policies and procedures related to the management of the medication program were not clearly understood by staff interviewed, and not implemented in a consistent manner by all staff.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that Silver Fox Pharmacy's policy on the drug destruction of controlled substances was a recommendation to the licensee. However, the Administrator told the inspectors that the medication management program policies and procedures developed by Silver Fox Pharmacy are the policies and procedures for the home. The Administrator also said that the licensee expected that staff would follow Silver Fox Pharmacy's policies and procedures, and that staff had been trained and told to follow Silver Fox Pharmacy's policies and procedures. This training was provided to registered staff by Silver Fox Pharmacy on specified dates in 2016. Despite this, the licensee has a number of other policies and procedures that were developed by the licensee related to the management of the home's medication program that are currently in force and available to all staff.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that the Silver Fox Pharmacy has been a service provider in long-term care homes since June, 2016. The Pharmacy Consultant said that the policies and procedures provided by Silver Fox Pharmacy have been developed, implemented, evaluated, and updated in accordance with evidence best practices, and if there were none in accordance with prevailing practices, and that the policy and procedures provided by Silver Fox Pharmacy are based on requirements in the Long-Term Care Homes Act, 2007, and that they are based on prevailing practices from the College of Nurses of Ontario, and the Ontario College of Pharmacists.

A. Silver Fox Pharmacy's policy on the disposal and destruction of non-controlled substances that is based on evidence-based and prevailing practices and that is utilized by the licensee was not implemented.

The Licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Disposal of Non-Controlled Medication", Policy 5.6, dated June 2016 as the policy of the home. Silver Fox Pharmacy Consultant told the inspectors that this policy is based on prevailing practices within the industry. This policy states in part:

The following medications should be placed in buckets, transdermal patches, medications removed from the blister packets and med strips. Inhalers, liquid, nasal, eye and ear preparations are opened and dumped. Vials, cartridges, and ampules are opened and emptied. Creams and ointments are opened and dumped.

An annual schedule of medication destruction pick up dates was provided to the homes at the beginning of each calendar year.

Medications awaiting destruction must be stored in a secure, designated area within the home, separate from medications that were to be administered to the residents.

The Medication Destruction Form should be signed and dated by both of the staff members who participated in the medication destruction.

The Medication Destruction Form must be retained in the home by the Director of Care for a minimum of 2 years.

The licensee also utilized Silver Fox Pharmacy's policy titled "Safe Storage of Medication" Policy 5.1 dated June 2016. Silver Fox Pharmacy Consultant told the inspectors that this policy is based on prevailing practices within the industry. This policy states in part that:

Unused or wasted medication should be stored away from active medication in a locked area until it can be returned to Silver Fox Pharmacy.

The licensee also has a policy that it developed for drug disposal. The licensee's current policy titled "Residents Rights, Care and Services, Medication Management, Drug Disposal" with a revised date of 2013-10-07 states in part:

All medications which are discontinued, unused, expired, recalled, deteriorated, unlabelled and in containers with worn, illegible, damaged, incomplete or missing labels shall be removed from general stock and stored in a safe and secure system awaiting drug destruction. Drug disposal shall be documented on the Surplus Prescribed Drug Form after destruction has occurred.

The Surplus Prescribed Drug Form will be completed in full detailing the following information: date of destruction or removal of the drug, prescription number of the drug, Pharmacy name, resident's name, drug name, strength and quantity, reason for destruction or removal.

The Director of Care will retain a copy of the Surplus Prescribed Drug Form for a two (2) year period.

The licensee's current policy titled "Residents Rights, Care and Services "Medication Management Drug Disposal" is not the same as Silver Fox Pharmacy's policy titled "Documentation and Storage of Medications Disposal of Non-Controlled Medications".

During an interview, Silver Fox Pharmacy Consultant told the inspectors that according to its drug destruction policy, the non-controlled substances were to be denatured to an extent where consumption or use was improbable; and that all drug components and anything considered a medication would be going into the buckets for destruction even though syringes were not something recommended to be placed in these buckets.

Inspectors #610 and #658 observed the medication rooms and medication carts of the four home medication storage areas and noted the following:

In one medication cart there was one specific medication with a pharmacy label that was illegible, and did not have any resident identifying information. In one medication cart there was one specific medication with a pharmacy label that was illegible and damaged, and a second medication label that was illegible, and had incomplete information. As a result, it was not possible to identify which resident these medications were prescribed to.

In the top drawer of one medication cart, there was a specific medication, which had an expiry date. In one medication cart, there was a specific medication, which had an expiry date.

Underneath one medication room sink there was a white bucket being used as a drug destruction container labelled "MPLN BLUE" and inside the bucket there was disposed pills, inhalers, glass vials,

insulin cartridges, and a syringe. The lid to the white bucket was not securely fastened and the inspectors were able to remove the lid from the bucket. Resident personal health information (PHI) was found in this bucket with disposed medication.

Underneath one medication room sink, the inspectors found medications (including expired medications that had not been administered to residents on the date and time as per the directions from the prescriber), that were opened and left in medication cups, as well as unopened resident strip medication packages.

In one medication room there was medication in a brown box on the floor next to several white garbage bags that contained residents' medication packages with the residents' PHI.

In one medication room there was a white bucket being used as a drug destruction container, and inside the bucket there were resident identifiers, and the lid to the bucket was not securely fastened as the inspectors were able to remove the lid from the bucket.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home showed that audits were completed by Silver Fox Pharmacy for a three months period in 2016.

The audits identified, among other things, that the licensee had not ensured the Silver Fox Pharmacy's policies and procedures were followed and implemented for medication drug destruction for non-controlled drug-substances, and that medication audits of carts had not been completed to ensure the removal of expired medication.

The Director of Care said that Silver Fox Pharmacy had brought to her attention that the drug destruction records were not being kept or completed correctly by the registered staff for destruction of non-controlled drug substances.

During an interview, the Administrator acknowledged to the inspectors that the licensee's expectation was that all unlabeled or expired medications, or containers with worn, illegible, damaged, incomplete or missing labels would be destroyed and replaced. The Administrator stated that the drug destruction of medications would be completed per the policy of the home, and that syringes would be disposed of in a sharps container. The Administrator acknowledged that the licensee should have been following Silver Fox Pharmacy's policy and procedure for the medication destruction of non-controlled drug substances and had not.

The licensee failed to ensure that Silver Fox Pharmacy's policy on the disposal and destruction of non-controlled substances that is based on evidence-based and prevailing practices, was implemented as medications were not put in buckets, medications awaiting destruction were not stored in a secure, designated area within the home, separate from medications to be administered to residents, and unused or wasted medication was not stored away from active medication.

B. Silver Fox Pharmacy's policy on the management of narcotics and controlled substances which is based on evidence-based practices and prevailing practices, and utilized by the licensee, was not implemented.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016 as the policy of the home. Silver Fox Pharmacy Consultant #109 told the inspectors that

this policy is based on prevailing practices within the industry. This policy states in part that counts must be done at every shift change with two staff members on the Controlled Substance Shift Count Record. Both staff members must be present and complete the count together.

An audit of the daily controlled substances count sheet is to be completed by the staff at the home on a monthly basis. All discrepancies must be reported immediately to the Director of Care.

The licensee also has a policy that it developed for the management of narcotics and controlled substances. The licensee's current policy titled "Medication Management Narcotics and Controlled Substances" with a revised date of 2013-10-07 states in part:

A count of narcotics shall be completed by the off going and incoming registered staff member at change of shift and whenever an exchange of medication keys takes place. All Narcotic counts shall be documented in permanent ball point ink.

The licensee's current policy titled "Medication Management Narcotics and Controlled Substances" is not the same as Silver Fox Pharmacy's policy titled "Documentation and Storage of Medication Controlled Substance Documentation".

A review of the Controlled Substance Shift Count sheets provided by Silver Fox Pharmacy with a date range of October 24, 2016 to November 11, 2016, showed that on October 24, 25, 26, 27, and 30, and November 2, 3, 4, and 6, 2016, that two staff had not counted and verified the controlled substances of every shift. On these specified dates, registered staff had failed to complete the signage on the Controlled Substance Shift Count sheets. The counting and verifying by two staff of controlled substances at every shift change was not completed as required by Silver Fox Pharmacy's policy, which is the policy of the home.

During an interview, the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each shift when completing the narcotic count.

The Silver Fox Pharmacy Consultant said that they provide education to staff as well as all documents for drug record or administration of controlled substances. But if that didn't happen, their role as the pharmacy service provider in relation to the medication management system as a whole, is to notify management and try to coordinate a plan to minimize the recurrence of any errors.

The Staff Educator said that the registered nursing staff received education related to Silver Fox Pharmacy's policies and procedures on August 22 and 23, 2016.

The licensee failed to ensure that Silver Fox Pharmacy's policy on the management of narcotics and controlled substances that is based on evidence-based and prevailing practices and that is utilized by the licensee was implemented as two staff had not counted, verified and documented on the count sheets for controlled substances at every shift change.

The licensee has failed to ensure that no drug is acquired, received or stored by or in the home or kept by a resident unless the drug (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, or (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122(1).

On a specific date and time, the inspectors observed one medication room and medication cart and noted that in the locked box in the medication cart there were two bottles of a specific medication.

Neither bottle of medication had labels or packaging information provided by the pharmacy. Instead, the two bottles had a piece of tape on the lid on which the resident's first name and quantity of medication were hand written.

During an interview, Silver Fox Pharmacy Consultant was shown pictures of the two bottles of a specific medication. Silver Fox Pharmacy Consultant stated that they did not believe those bottles were provided by Silver Fox Pharmacy and that they understood, according to the Act, that medications only came from the pharmacy service provider or the Government of Ontario Pharmacy.

During an interview, DOC told the inspectors, when asked about the labelling on the medication bottles, that the home does not receive medications from Silver Fox Pharmacy without labelling.

The licensee failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident unless the drug (a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply, or (b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario Pharmacy.

The licensee has failed to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

On a specific date and time, inspectors #610 and #658 observed the medication cart in one medication room and noted that there were medications in medication cups for three residents in the fourth drawer. As the medications were in medication cups, they were not in the original labelled package provided by the pharmacy. The only information identifying the medications was the top of the strip packages provided by the pharmacy including: the resident's name, and date and time of administration which was for specific time on a specific date. There was no identifying information connecting the resident to the medications in the cups to identify who was to receive the medications. As a result, the medications were in the medication cups for approximately 2.5 hours, and not in their original labelled packaging provided by the pharmacy.

On a specific date, the inspectors observed one medication cart and noted that there was one medication with a pharmacy label that was illegible and damaged, and also a second medication label that was illegible and had incomplete information. It was not possible to identify which residents these medications were prescribed for.

On a specific date and time, the inspectors observed one medication room and medication cart and noted the following:

There was one medication with a pharmacy label that was illegible and did not have any resident identifying information. There was also a medication with a Silver Fox Pharmacy label that was worn off and the resident's name and "NR" were hand-written with ink. It was not possible to identify which residents these medications were prescribed for.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Safe Storage of Medication" Policy 5.1 dated June 2016. This policy states in part:

All medication should remain in the original Silver Fox container until they are administered to an individual; and unused or wasted medication should be stored away from active medication in a locked area until it can be returned to Silver Fox Pharmacy.

The licensee also has a policy that it developed pertaining to the packaging and labelling of medications. The licensee's current Policy titled "Administration of Medications" with a revised date of 2015-07-24 states in part:

Administer medication only from properly labelled vials, packages, strip pouches, and blister packs dispensed from pharmacy.

During an interview, Silver Fox Pharmacy Consultant said that the expectation of labelling and packaging of medications was that anything that came from the pharmacy service provider would not be altered, and that if a medication had an illegible label, the medication would be removed and would not be used for administration.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home showed that audits were completed by Silver Fox Pharmacy for the months of September, November, and December 2016. The audits identified, among other things, that labelling of insulin cartridges and medication did not have the pharmacy labels for resident identifiers and prescribed orders.

During an interview, the Administrator acknowledged that missing or illegible labels should be replaced on unlabeled and expired medications, or on containers with worn, illegible, damaged, incomplete, or missing labels.

The licensee failed to ensure that drugs remained in the original labeled container or package provided by the pharmacy service provider until administered to a resident or destroyed.

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1)(b).

On a specific date and time, the inspectors observed the medication room and medication cart for one home area. The inspectors observed controlled substances within the locked medication cart in the fourth drawer with non-controlled medications. Specifically, the inspectors observed controlled substances: ampules left in a medication cup that had been opened and used for a resident, with a clear substance remaining in both ampules. Upon further review, the medication cart contained a separate locked area in the bottom drawer but these controlled substances were not in that separate locked area.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016. This policy states in part that:

Every controlled substance in the home must be stored separately from other items and must be double locked.

The licensee's current policy titled "Medication Management-Drug Storage" with a revised date of 2013-10-07 states in part that:

Staff are to ensure that all narcotics are stored in a double locked, permanently affixed compartment within the general medication cart and or medication room.

On a specific date, due to the immediate risk presented by the opened and unsecured medication, the inspectors asked the Administrator to observe the controlled substances that were in the fourth drawer of the medication cart. The Administrator observed the fourth drawer of the medication cart and told the inspectors that the opened and unsecured medication were not stored in accordance with the licensee's policy on the storage of narcotics.

After the inspectors brought the unsecured medication to the attention of the Administrator, a medication incident report was completed.

During an interview, a registered staff member told the inspectors that they completed a medication incident report, regarding the opened and unsecured controlled narcotic medications ampules that were observed by the inspectors. The registered staff member said that the process for using and discarding a controlled substance was to:

Withdraw the amount required for the resident; Leave any remaining unused medication in the ampule; Co-sign with the second nurse; and Discard the ampule with the unused medication into the sharps container.

The medication incident report related to the inspector's observation showed that the staff received re-education on the licensee's drug disposal policy, a quiz on the medication practice standard from the College of Nurses of Ontario, and a written warning from the Director of Care.

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

The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including that a monthly audit was 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. O. Reg. 79/10, s.130. 3.

Silver Fox Pharmacy completed its own audits for September, November, and December, 2016, regarding the medication management system in the home. These audits showed that the licensee had not completed audits of the daily count sheets for controlled substances to verify counts and to resolve any discrepancies immediately.

During an interview, the DOC told inspector #658 that they have a tool to audit the controlled substances, that this audit process was the responsibility of the DOC, and had not been implemented.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Controlled Substance Documentation" Policy 5.3 dated June 2016. This policy states in part:

Counts must be done at every shift change with two staff members on the Controlled Substance Shift Count Record. Both staff members must be present and complete the count together.

An audit of the daily controlled substances count sheet is to be completed by the staff at the home on a monthly basis. All discrepancies must be reported immediately to the Director of Care.

The DOC told the inspectors that the licensee had not completed monthly audits of the controlled

substances as per the home's policy for August 2016, to January 12, 2017, and that the licensee's expectation is that monthly audits are completed and that any discrepancies are addressed immediately.

During an interview, the Administrator told the inspectors that the licensee's expectation was that two registered staff would sign off on each narcotic count and completed at every shift change.

A review of the Controlled Substance Shift Count sheets provided by Silver Fox Pharmacy with a date range of October 24, 2016 to November 11, 2016, showed that on October 24, 25, 26, 27, and 30, and November 2, 3, 4, and 6, 2016, that two staff had not counted and verified the controlled substances on every shift. On these specified dates, registered staff had not signed the Controlled Substance Shift Count sheets.

In an interview with the DOC, they said they were aware of the results of the missing signatures on the controlled substance records by the pharmacy audits and staff informing them.

The licensee failed to ensure that a monthly audit was 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 licensee has failed to ensure that no drug was administered to residents unless the drug was prescribed for the resident. O. Reg. 79/10, s. 131 (1)

A Controlled Substance Administration Record for an identified resident was reviewed in one of the medication rooms. The record showed that the resident received a specific controlled substance every four hours as needed. Record review of a second identified resident indicated that they had an order for a specific controlled substance every six hours as needed. The Controlled Substance Administration Record for the first resident indicated that the same medication that was ordered, purchased, and prescribed for the resident was borrowed and administered to the second resident four times in two days.

The Controlled Substance Administration Record for the second resident showed that on a specific date, the resident was given one dose of the controlled substance, and on the next day, three more doses of the controlled substance were administered to the resident from the first resident's medication card.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that if staff ran out of medications, they would access the emergency drug supply first, and then contact the on-call pharmacist. Silver Fox Pharmacy Consultant further explained that borrowing medication (giving a resident the medication that was prescribed for another resident) was not a practice they recommended and that the medication for the second resident should have been reordered as required. The Silver Fox Pharmacy Emergency Pharmacy Procedures Policy 3.9 states:

Silver Fox Pharmacy provided 24/7/365 emergency medication service outside of their business hours.

The licensee's current policy titled "Administration of Medication" with a revised date of 2015-07-24 states in part that staff are to: "Apply the "rights" of medication administration, including the right resident".

During an interview, the DOC told the inspectors that the licensee's expectation was that residents would only be administered medications that were ordered and prescribed for that resident, and dispensed to that resident by the home's pharmacy service provider.

The licensee failed to ensure that the identified resident was only administered medication that was prescribed for them.

The licensee has failed to ensure that no person administered a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered practical nurse or a nursing student O. Reg. 79/10, s. 131 (3)

On a specific date and approximate time, a registered staff member was observed pouring an identified medication that was prescribed for an identified resident. The registered staff member proceeded to the dining room and gave the identified medication to a non-registered nursing staff member. The registered staff member then walked back to the medication cart, and the inspectors observed the PSW administer the medication to the resident.

The licensee's current policy titled "Medication Administration Record", with a revised date of 201507-24 states:

"All medications shall be administered only by those authorized under the Health Professionals Act and their respective regulatory colleges".

The registered staff member told the inspectors that the identified medication was on the eMAR and registered staff signed for the identified medication as prescribed for the resident.

The Administrator told the inspectors that their understanding was that whoever poured the medication administered the medication, and acknowledged that the identified medication was a medication that should not be administered by PSW's.

The licensee failed to ensure that no person administers a drug to a resident in the home unless that person was a physician, dentist, registered nurse or a registered a practical nurse.

The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which the following information was recorded, in respect of every drug that was ordered and received in the home:

1. The date the drug was ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

On a specific date, the inspectors reviewed the drug record book in one medication room, which showed that an identified resident had a controlled substance re-ordered for them on a specific date.

The medication was received for the resident on a specific date per the medication label on the medication card in the controlled medication bin in the medication cart. The resident was administered the medication the following seven days after being received. For this medication received for the identified resident, the drug record book did not include the prescription number, the quantity of tablets, or the signature of the person acknowledging receipt of the drug on behalf of the home.

The inspectors reviewed the drug record book in one home area with a date range from October 1 to October 31, 2016. The drug record book showed that a total of 122 drug re-orders were made during this time period. 116 of the 122 drug re-orders were not completed in their entirety as the drug record for each of these 116 re-orders did not show the quantity of the drug that was ordered, the prescription number for the drug that was ordered, the date the drug was received in the home, or the signature of the person acknowledging receipt of the drug on behalf of the home.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Drug Record" Policy 3.3 dated June 2016. This policy states in part:

The Drug Record (DR) was intended to be a record of all medications that were ordered and received by the home. Once the new or repeated medication had been received at the home, the person checking it in will sign, date, record the new prescription number and the quantity received. Any staff member may check the DR to verify that the medication had been received within the home.

Silver Fox Pharmacy Medication System Audit Reports regarding the medication management system in the home for audits that were completed by Silver Fox Pharmacy for the months of September, November, and December 2016 identified, among other things, that the drug record book was not being maintained and drug records were not kept, and that the drug record book was not being signed properly for ordering and re-ordering and receiving of medication by staff.

The Administrator told the inspectors that when the medication was delivered to the home from the pharmacy, it was the expectation that staff would be signing in the delivered medications in the drug record book.

The licensee failed to ensure that the following information was recorded in the drug record in respect of every drug that was ordered and received in the home, in accordance with O. Reg. 79/10, s. 133:

3. The quantity of the drug;
6. The prescription number;
7. The date the drug was received in the home; and
8. The signature of the person acknowledging receipt of the drug on behalf of the home.

The licensee failed to ensure that a plan, policy, protocol, procedure, strategy or system that is required by the Long-Term Care Homes Act, 2007 or O.Reg. 79/10 was complied with. O.Reg. 79/10, s. 8(1) (b).

The licensee is required by O. Reg. 79/10, s. 136(1) to have a written drug destruction and disposal policy. O. Reg. 79/10, s. 136(4) states that the written drug destruction and disposal policy must provide that where a drug that was to be destroyed was a controlled substance, the applicable team members document the following in the drug record: the date of removal of the drug from the drug storage area; the name of the resident for whom the drug was prescribed, where applicable; the prescription number of the drug, where applicable; the drug's name, strength and quantity; the reason for destruction; the date when the drug was destroyed; the names of the persons who destroyed the

drug; and the manner of destruction of the drug.

The licensee utilized the pharmacy service provider Silver Fox Pharmacy, and their policy titled "Documentation and Storage of Medication Disposal of Controlled Medications" Policy 5.7 dated June 2016. This policy states in part:

With two registered staff members present, the remaining quantity of medication is circled on the controlled substance administration record and documented in the appropriate space. A diagonal line should be drawn through the remaining spaces on the count sheet space; the reason for the destruction should be documented on the count sheet. The form is to then be signed in the appropriate space by two registered staff.

The inspectors reviewed the controlled substance administration records for five residents with dates ranging from September to October, 2016, and identified that all of the sheets were incomplete. Review of all five residents' controlled substance administration records showed that the reason for the drug destruction, the two registered staff signatures signed for when controlled substances were removed, the quantity removed, and the removal dates were not documented. Four out of the five controlled substance administration records did not have the remaining quantity of the medication circled, and two of the five records did not have a diagonal line drawn through the remaining spaces as directed by Silver Fox Pharmacy's policy.

During an interview, Silver Fox Pharmacy Consultant told the inspectors that they believed that staff were educated on how to use the controlled substance administration record for destruction and that it would have been covered during the education provided by Silver Fox Pharmacy to registered staff in the home on August 22 and 23, 2016.

During an interview, the Administrator told the inspectors that it was an expectation that the home would be following the policy from Silver Fox Pharmacy related to drug destruction of a controlled substance.

The licensee failed to comply with the drug destruction and disposal policy required by O. Reg 79/10, s. 136(1) by failing to ensure that where a controlled substance was destroyed the applicable team members documented the information required by s. O. Reg. 79/10, s. 136(4).

The licensee failed to comply with O. Reg. 79/10, s. 134(b), ensuring that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

An identified resident's pain assessment in PCC completed on admission, showed that the resident was receiving pain medication for specific diagnoses.

Review of the eMAR showed that the resident was to receive pain medication twice a day at specific times.

On a specific date, the progress notes for the resident created by a registered staff member showed that the resident had not received their pain medication at both specific times as prescribed.

Further review of the eMAR and PCC showed that there was no further action taken to respond to the omission of medication, and the resident had not been reassessed for pain management.

During an interview, the registered staff member told the inspectors that they did not give the medication to the resident as prescribed, had not completed a medication incident report and that there was no further action taken to assess the resident's pain as a result of the omission of medication.

The DOC told the inspectors that they were not aware of the medication incident for the identified resident and that a medication incident report should have been completed and had not been completed.

The licensee failed to ensure that appropriate actions were taken in response to the medication incident involving the identified resident.

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le : April 5, 2017**

## 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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

| | |
|---|---|
| À l'attention du registraire<br>Commission d'appel et de révision des services de santé<br>151, rue Bloor Ouest, 9e étage<br>Toronto (Ontario) M5S 2T5 | Directeur<br>a/s Coordinateur des appels<br>Inspection de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Ontario, ON<br>M5S-2B1<br>Fax: 416-327-7603 |

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 6th day of February, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Natalie Moroney

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