Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 15, 2020	2020_782736_0014	009603-20	Critical Incident System

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Oak Terrace
291 Mississaga Street West ORILLIA ON L3V 3B9

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

AMANDA BELANGER (736)

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): July 6-9, 2020.

During the course of this Critical Incident inspection, the following log was inspected:
-one log, related to a report submitted to the Director for a missing or unaccounted for controlled substance.

A Follow Up Inspection, #2020_782736_0013, was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Director of Care (DOC), Registered Nurse(s) (RNs), Registered Practical Nurse (s) (RPNs), and Personal Support Worker(s) (PSWs).

During the course of the inspection, the Inspector(s) reviewed the licensee's relevant internal investigation notes, relevant policies and procedures, resident health records, and observed the provisions of care, including medication administration.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

In accordance with O.Reg 79/10, s. 136 (4), the licensee was required to ensure that when a drug that was to be destroyed was a controlled substance, the drug destruction and disposal policy was to provide that team composed of persons referred to in clause (3) (a) would document: (5) the reason for destruction, and (7) the names of the members of the team who destroyed the drug, in the drug record.

a) Specifically, staff did not comply with the licensee's "LTC-Narcotics and Controlled Drug Management- ON", policy #CARE13-020.02-ON, last modified March 31, 2018, which is part of the licensee's Medication Management Program, which indicated that when staff were disposing of narcotic and controlled drugs, any wastage was to be double witnessed and signed by two nurses. The Narcotic and Controlled substance count sheet was to have an explanation regarding the waste and the unused portion was to be discarded.

A Critical Incident (CI) report was submitted to the Director related a missing or unaccounted for controlled substance. The CI report indicated that on a specific date, at the start of the shift, the narcotic count was correct for the emergency stock of a specific

controlled substance, however, later on the same date, the medication was signed for as removed from the emergency box, but no resident was listed as receiving the medication.

Inspector #736 reviewed the licensee's internal investigation notes related to the missing or unaccounted for controlled substance, and noted a "Narcotic and Controlled Substance Administration Record" for resident #004, related to their controlled substance. The Inspector noted that on the specific date, at a specified time, the controlled substance was signed as administered to the resident, with an amount wasted. The Inspector noted that there was no signature in the "witnessed by" location.

In separate interviews with Registered Nurse (RN) #102 and Registered Practical Nurse (RPN) #105, they indicated to the Inspector, that the policy and protocol in the home when administrating a controlled substance, was that if there was any of the medication to be wasted, the nurse would need to have a second nurse witness and sign off on the waste.

In an interview with the Director of Care (DOC), they indicated that during the course of the investigation into the missing or unaccounted for controlled substance, it was noted that on specified date, RPN #103 had signed off as having wasted a specific amount of a controlled substance, but had no second nurse had witnessed the wastage. The DOC indicated that as there was no second signature, and no nurse working that evening recalled having witnessed the wastage of the controlled substance, RPN #103 did not comply with the home's policy related to medication administration and the wastage of controlled substances.

b) Specifically, staff did not comply with the licensee's "Narcotic and Controlled Substances Administration Record", policy #MEDI-CL-ONT-042, last revised July 19, 2018, and effective August 20, 2018, which is part of the licensee's Medication Management Program, which indicated that all entries were to be made on the Narcotic and Controlled Substance Administration record, at the time the drug was removed from the container.

Inspector #736 reviewed the licensee's internal investigation notes into the missing or unaccounted for controlled substance, which included a report that indicated that on an earlier date, it was noted that RPN #103 had given a medication to a resident, but during the evening shift, forgot to document the administration.

In separate interviews with RPN #105 and RN #102, they indicated that the process in the home for administrating a narcotic or controlled substance to a resident, included signing for the medication administration on the resident's individual Narcotic and Controlled Substance Administration Record. RN #102 also indicated to the Inspector that prior to the date of when a controlled substance was noted to be missing or unaccounted for, there had been another instance where RPN #103, had not signed for the administration of a controlled substance to a resident.

In an interview with the DOC, they indicated to the Inspector that prior to the missing or unaccounted for controlled substance, it had been noted that on an earlier date, RPN #103 had given a controlled substance to a resident, however, had not documented the administration of the medication on the Narcotic and Controlled Substance Administration Record for the resident. The DOC indicated that, as the Narcotic and Controlled Substances Administration Record had not been completed by the RPN, the home's policy related to medication administration had not been complied with and should have been. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the policies related to medication administration, specifically, the administration and waste of controlled substances, are complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area with the locked medication cart.

A CI report was submitted to the Director on a specified date, related to a missing or unaccounted for controlled substance. The CI report indicated that six days prior, at a specific time, the count for a controlled substance went to zero. The staff were unable to recognize the signature of who drew the medication and no resident name was listed.

The Inspector reviewed the licensee's internal investigation package into the missing or unaccounted for controlled substance. The Inspector noted that within the investigation notes, RN #107 had indicated to the DOC that they had found a vial of medication in the medication cart in a medication cup and discarded it. The investigation notes also indicated that RPN #103 had told the DOC and ED that they had placed a discarded narcotic in a cup in the medication cart.

In separate interviews with RPN #105 and RN #102, they both indicated that narcotics and controlled substances were kept in the medication cart, in a second locked box in the cart.

A review of the licensee's policy, titled "LTC-Narcotics and Controlled Drugs Management-ON, policy #CARE13-020.02-ON, last updated March 31, 2018, indicated that all narcotics and controlled drug(s) were to be stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

In an interview with the DOC, they indicated to the Inspector, that RN #107 had told the DOC that they found a vial of a controlled substance in a cup in the a drawer of the medication cart. The DOC further indicated that the specific drawer of the medication cart was not double locked. The DOC confirmed that as the controlled substance was located in the drawer of the medication cart, the controlled substance had not been kept double locked and should have been. [s. 129. (1) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that certain matters were reported to the Director within one business day.

A CI report for a missing or unaccounted for controlled substance was submitted to the Director on a specific date. The CI report indicated that the home first noticed a discrepancy in the controlled substance count six days prior.

The CI report indicated that on a specific date, at a shift change, the count for a controlled substance was correct; however, later on the same date, the count went to zero. The staff on shift were unable to recognize the signature of who took the medication from the emergency box and were unable to determine which resident the medication had been removed for.

The Inspector reviewed the licensee's internal investigation notes into the missing or unaccounted for controlled substance. Within the investigation package, the Inspector reviewed related to RPN #103's interview with the Executive Director; the document indicated that it was identified four days prior to the report being submitted to the Director, that the home was unable to reconcile the count of the controlled substance.

The document also indicated that RPN #103 had been spoken to prior to the report being submitted to the Director, related to issue of unaccounted for controlled substance.

The internal investigation package also had an email from RN #102 to the Director of Care (DOC), four days prior to report being submitted to the Director, which indicated that it appeared that the home was "only missing one dose of [controlled substance]" from the emergency stock box.

The internal investigation notes provided to the Inspector by the DOC, indicated that various staff members who had been working on date when the controlled substance was noted to be missing or unaccounted for, were interviewed on one, two and three days prior to the report being submitted to the Director, related to the missing or unaccounted for controlled substance.

A review of the licensee's policy, titled "LTC-Narcotics and Controlled Drugs Management-ON", policy #CARE13-020.02-ON, last modified March 31, 2018, indicated that if there was a discrepancy in the narcotic count, the Nurse was to immediately inform the DOC/designated Nurse and a through investigation would be initiated. The policy also indicated that any unexplained discrepancy would be reported immediately to the MOHLTC as required.

In an interview with the DOC, they indicated to the Inspector that they were unsure of the time line reporting requirements to the Director for a missing or unaccounted for controlled substance. The DOC confirmed that the home was aware of the missing or accounted for controlled substance on a specified date; however, did not report to the Director within one business day, as the home was unsure if the controlled substance was missing, or if staff had not correctly followed the policy of the home.

In an interview with the Executive Director (ED), they indicated that they were aware that a missing or unaccounted for controlled substance was to be reported to the Director within one business day. The Inspector reviewed the CI report time line with the ED, and the ED indicated that the report was not submitted to the Director within one business day. The ED further indicated that the report should have been submitted to the Director within the time line of one business day, and could have been amended if the home had located the controlled substance. [s. 107. (3) 3.]

Issued on this 15th day of July, 2020

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

Original report signed by the inspector.