Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: February 15, 2023	
Inspection Number: 2023-1167-0002	
Inspection Type: Critical Incident System	
Licensee: Maryban Holdings Ltd.	
Long Term Care Home and City: Oakwood Park Lodge, Niagara Falls	
Lead Inspector Jonathan Conti (740882)	**Inspector Digital Signature**
Additional Inspector(s) Erin Denton-O'Neill (740861)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 27, 30-31, and February 1-2, 2023.

The following intakes were inspected:
- Intake: #00002763- [CI: 2661-000004-22] was related to a resident fall resulting in injury.
- Intake: #00003374- [CI: 2661-000003-21] was related to controlled substance missing.

The following intakes were completed in this inspection: Intake: #00002942- [CI: 2661-000008-21]; Intake: #00003608- [CI: 2661-000005-21]; and Intake: #00005053- [CI: 2661-000006-22] were all related to falls.

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Falls Prevention and Management

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Drug Destruction and Disposal

NC # Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 136 (3) (a)

The licensee failed to ensure that as part of the home's medication management system, drugs of a controlled substance were destroyed by a team acting together and composed of i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and ii) a physician or a pharmacist.

Rationale and Summary
A critical incident report for a missing controlled substance was submitted to the Director on a day in February 2021, related to a missing controlled substance.

Policy 6-7 from Care RX Pharmacy titled “Surplus discontinued narcotics and controlled medications”, indicated that narcotics were to be destroyed by a nurse and the pharmacist together. The policy supports the requirement for the assigned registered staff member and pharmacist to also record and sign off on the confirmation of the quantity being discarded. Only medications that have been properly documented and authorized are to be destroyed as per policy.

The investigative notes indicated that on a day in February 2021, a Registered Practical Nurse (RPN) identified and reported to the Administrator that a controlled substance was missing. A search was done by the RPN, and an investigation was completed by the Administrator and Director of Care (DOC) and the controlled substance was not found.

The RPN stated that they noticed the missing narcotic after they completed their medication administration for their shift on a day in February 2021. They stated that the medication card was thrown in the garbage accidentally. The DOC confirmed that the home failed to ensure that drugs of a controlled substance were destroyed by a team as per legislative requirements.

Sources: Interviews with DOC and RPN, the home’s investigative notes, incident report, Care RX policy 6-7, “Surplus discontinued Narcotics and controlled medications”- last reviewed January 2022, and Critical Incident Report 2661-000003-21.

[740861]