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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 16, 2019	2019_736689_0015	001197-18, 010648-18, 015235-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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

Ridgeview
385 Highland Road West STONEY CREEK ON L8J 3X9

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

CASSANDRA ALEKSIC (689)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 6, 7, 8, 9 & 10, 2019.

The following intake was completed in this Critical Incident System Inspection:

Critical Incident Log # 010648-18 / CI 2849-000006-18 related to medication management;
Critical Incident Log # 001197-18 / CI 2849-000002-18 related to responsive behaviours and prevention of abuse and neglect; and
Critical Incident Log # 015235-18 / CI 2849-000008-18 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Assistant Director of Care, the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, a Registered Practical Nurse, Personal Support Workers and a resident.

The inspector also reviewed health care records and plans of care for identified residents, the home's investigative notes, and the home's policies and procedures.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **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, the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10 s.114 (3) states, "The written policies and protocols must be, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices."

Specifically, staff did not comply with the home's policy "LTC - PRN Medications – Administration and Documentation" with reviewed date March 31, 2018, which is part of the licensee's Medication Management program.

A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date documented an incident of "controlled substance missing/unaccounted."

Review of the CIS report showed documentation that during the evening shift change on a specific date, two nurses completed the narcotic shift count. The report documented that during the count of a box of narcotic ampules, each containing 10 vials, the first set of five ampules were intact and the second set of five ampules were all broken and the contents gone. The report stated that during the homes internal investigation, all

registered staff members that were in contact with the medication in question were interviewed and a potential suspect had been identified and that a Registered Nurse (RN) had been put on administrative leave pending the investigation. The report documented that a second interview concluded that on 57 occasions, the suspected RN signed out as needed (PRN) narcotics for two residents on the narcotic control count form, but did not document in the electronic Medication Administration Record (eMAR) or progress notes that the PRN narcotic was given, the reason why, and the outcome.

The home's investigative notes and clinical records for resident #004 were reviewed and showed the following:
-A physicians order for resident #004 showed the directions for a PRN narcotic, with a specific order date.
-The Narcotic and Controlled Substance Administration Record showed that resident #004's PRN narcotic was documented by the RN as "administered by" on 29 occasions for a specific time frame.
-The electronic Medication Administration Record (eMAR) for a specific time frame showed no documentation of the residents' PRN hydromorphone by the RN for 23 out of 29 (79 per cent) occasions of administration as recorded on the Narcotic and Controlled Substance Administration Record.
-There were no progress notes in the residents' clinical record which documented the administration of narcotic PRN or the residents' pain level on the same 23 out of 29 (79 per cent) occasions of administration as recorded on the Narcotic and Controlled Substance Administration Record.

The home's investigative notes and clinical records for resident #005 were reviewed and showed the following:
-A physicians order for resident #005 showed the directions for a PRN narcotic, with a specific order date.
-The Narcotic and Controlled Substance Administration Record showed that resident #005's PRN narcotic was documented by the RN as "administered by" on 28 occasions for a specific time frame.
-The electronic Medication Administration Record (eMAR) for a specific time frame showed no documentation of the residents' PRN narcotic by the RN for 22 out of 28 (78 per cent) occasions of administration as recorded on the Narcotic and Controlled Substance Administration Record.
-There were no progress notes in the residents' clinical record which documented the administration of the PRN narcotic or the residents' pain level on the same 22 out of 28 (78 per cent) occasions of administration as recorded on the Narcotic and Controlled

Substance Administration Record.

The home's "LTC-Medication Management" policy, under "LTC-PRN Medications – Administration and Documentation" reviewed on March 31, 2018, stated the following:
-"the Nurse administering the PRN medication will assess the Resident before administration of the prescribed medication, and the assessment will be documented."
-"The Nurse administering the PRN medication will document on the MAR/TAR/interdisciplinary progress notes the following: date and time of administration; medication name, strength, and dosage given; Reason for administration and its effectiveness; Signature."

On a specific date, the Director of Care (DOC) stated that the process for the administration of narcotics or controlled substances would be that the registered staff would document on the resident's narcotic count sheet that the medication was administered. The DOC stated that the registered staff would document the administration of a PRN narcotic in the residents' eMAR in Point Click Care (PCC) which would prompt staff to make a structured progress note as to why the medication was administered and for the staff to document the residents' pain score. The DOC stated that the staff would then follow up with the resident on the medications effectiveness and staff were to complete another pain score. The DOC stated that out of the 57 times the RN documented that they had administered a PRN narcotic on the narcotic administration record for resident #004 and #005, 44 were incorrectly documented in the eMAR. When asked, the DOC stated that it was the expectation as per the home's medication management policies that the administration of the PRN narcotic medications for resident #004 and #005 should have been documented.

The College of Nurses of Ontario Report Form for Facility Operators and Employers completed on a specific date documented that during the homes investigation, management found that the RN signed out PRN narcotics on the Narcotic and Controlled Drug Administration Record 57 times in an eight week look back for two residents who were capable and cognitive. The report stated that the two residents were interviewed and said that they did not request PRN narcotic medication from the RN and did not receive the PRN narcotic medications. The report stated that the RN had been terminated from the home. The home also contacted the police who were notified of the incident.

The licensee has failed to ensure that the home's policy "LTC-PRN Medications – Administration and Documentation" related to the documentation of administered PRN

narcotic medication was complied with. [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 any policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident.

A Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) by the home on a specific date documented an incident of "controlled substance missing/unaccounted."

The CIS report documented the suspected Registered Nurse (RN) signed out as needed (PRN) narcotics for two residents on the narcotic control count form, but did not document in the electronic Medication Administration Record (eMAR) or progress notes that the PRN narcotic was given, the reason why and the outcome. The report documented that the residents who were capable stated they did not request a PRN narcotic.

The CIS report did not identify the name of the residents or the RN involved in the incident.

On a specific date, the Director of Care (DOC) verified the names of the residents and the RN and that they were not documented on the critical incident report and stated that they would expect that they should have been included.

The licensee failed to ensure that the report to the Director included the following description of the individuals involved in the incident, including the names of all residents involved in the incident, and the names of any staff members who were present at the incident. [s. 104. (1) 2.]

Issued on this 16th day of May, 2019

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

Original report signed by the inspector.