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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 1, 2016	2016_463616_0022	000900-16, 011878-16, 013976-16, 015796-16, 023624-16, 029610-16	Critical Incident System

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT 8TH FLOOR MISSISSAUGA ON L5R 4B2

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

ROSEVIEW MANOR
99 SHUNIAH STREET THUNDER BAY ON P7A 2Z2

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

JENNIFER KOSS (616)

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): September 7, 8, and 9, 2016.

This Critical Incident System Inspection is related to three incidents that the home submitted regarding missing/unaccounted medication and a medication incident resulting in resident transfer to hospital.

Concurrent inspections included Complaint inspection #2016_463616_0020 and Follow Up inspection 2016_463616_0021.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Clinical Services Manager, Documentation/Resident Assessment Instrument (DOC/RAI) Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family members, and residents.

During the course of the inspection, the Inspector(s) directly observed the delivery of care and services to residents, resident to resident interactions, reviewed resident health care records, various policies, procedures, and programs.

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	Legendé 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. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the Director in January, 2016, related to the discovery of six controlled substance tablets of various dosages in a medication cup in the medication cart. The home's investigation record identified that RPN #108 discovered the tablets when they lifted up a catheter bag from the back of the bottom drawer of the medication cart.

Inspector #616 reviewed the home's policy titled "Management of Narcotic and Controlled Drugs", revised date August 2012, which indicated that all narcotic and controlled drug(s) will be secured by double locking.

On September 9, 2016, during an interview with RPN #106 and RPN #102 separately, they both stated to the Inspector that controlled substances should have been stored in a separate locked box within the locked medication cart, stored in the locked medication room.

During the Inspector's interview with the Executive Director (ED), Clinical Services Manager, and the Director of Care (DOC) on September 9, 2016, they confirmed that the medications were a controlled substance, should have been locked in double locked storage area and were not. [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 stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A CIS report was submitted to the Director in May, 2016, related to a medication incident. In the report, RPN #107 had administered a co-resident's medications to resident #002 in error for which they were transferred to hospital for assessment and observation. The report indicated that at the time of administration, RPN #107 had asked a co-worker to identify resident #002. As a result of miscommunication between the staff members, a co-resident's medications were administered to resident #002.

Inspector #616 reviewed resident #002's Medication Administration Record (MAR) in effect at the time of the incident. The medications ordered for this resident did not include the co-resident's ordered medications.

In the home's policy titled "Medication Administration", #LTC-F-20, last revised August 2012, in effect at the time of the incident, indicated that medications will be administered following the "rights" of medication administration.

During an interview with the Inspector on September 9, 2016, the ED and the DOC confirmed that resident #002 should not have received medications that were not prescribed to them. [s. 131. (1)]

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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: 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 where the Act or this Regulation required the long-term care home to have, institute or otherwise put in place a policy for the medication management system, the policy was complied with.

A CIS report was submitted to the Director in August, 2016, related to a missing/unaccounted controlled substance. In the report, two registered staff had accounted for the controlled substances at shift change. After a medication pass, RPN #109 identified that the count for resident #006 was short by one controlled substance tablet.

On September 9, 2016, Inspector #616 reviewed the Unit Narcotic and Controlled Drug Count Sheets on resident #006's Home Area for the date of the incident. The drug count sheets included each resident's name and drug(s) name, as well as a section where incoming and outgoing staff signatures were required. There was no finding of missing

documentation for the date of the incident, however, in review of the drug count sheets for this particular Home Area, the Inspector noted there were staff signatures circled with a red pen on particular shifts. The Inspector then reviewed the Unit Narcotic and Controlled Drug Count Sheet for a different Home Area and noted that two signatures had also been circled on two different shifts.

In addition, the Inspector noted that both staff signatures for the incoming and outgoing shifts were missing for a particular shift on a date in September, 2016. Further, on this drug count sheet, the Inspector observed a post-it note which had a hand-written message that identified two staff names and read “sign pls” (please).

During interviews with RPN #106 and RPN #102 on September 9, 2016, they each stated to the Inspector that two registered staff were required to count the narcotics/controlled substances together, and sign off on the drug count sheets at shift change. RPN #106 explained that the post-it note on the drug sheet was intended to notify the particular registered staff that they had not signed the Unit Narcotic and Controlled Drug Count Sheet for this date and time.

The Inspector reviewed the home’s policy titled “Management of Narcotic and Controlled Drugs”, revised date August 2012, which indicated that two Nurses, one from the outgoing shift and one from the incoming shift, will count and sign off on the Narcotic and Controlled Drug Count Form every shift change.

On September 9, 2016, the DOC stated to the Inspector that they had reviewed the Unit Narcotic and Controlled Drug Count Sheets weekly, and where a signature was missing, they circled with a red pen. The DOC stated that after the weekly drug count sheets were reviewed, they had contacted the particular staff member to sign where they should have signed at the time of the count. The ED and the DOC confirmed to the Inspector that incoming and outgoing registered staff should have signed at each shift change as per policy, and when the shift was circled, registered staff had not followed the home's policy. [s. 8. (1) (b)]

Issued on this 21st day of December, 2016

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

Original report signed by the inspector.