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

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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2020	2020_648741_0008	004699-20, 006045-20, 006152-20, 007977-20, 009612-20, 009684-20, 009800-20, 013220-20	Critical Incident System

Licensee/Titulaire de permis

County of Oxford
21 Reeve Street WOODSTOCK ON N4S 7Y3

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

Woodingford Lodge - Woodstock
300 Juliana Drive WOODSTOCK ON N4V 0A1

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

AYESHA SARATHY (741)

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 14, 15, 16, 17, and 20, 2020 (On-site) and July 21, 22, and 23, 2020 (Off-site)

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

M632-000016-20 related to falls prevention and management
M632-000024-20 related to a missing/unaccounted for controlled substance
M632-000025-20 related to safe and secure home
M632-000017-20 related to resident to resident physical abuse
M632-000020-20 related to resident to resident sexual abuse
M632-000013-20 related to resident to resident sexual abuse
M632-000026-20 related to resident to resident sexual abuse
M632-000027-20 related to resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), a Registered Nurse (RN), a Maintenance Worker, a Physiotherapy Assistant, an Occupational Therapist (OT), Resident Care Coordinators (RCCs), the Manager of Resident Services (MRS), the Administrator and residents.

The Inspector also observed residents, storage of controlled substances in medication rooms and narcotic counts; and reviewed relevant policies and procedures, investigative reports and clinical records for identified residents.

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

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
1 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 :

The licensee has failed to ensure that where the Act or Regulation required 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 plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have written policies and protocols 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. Specifically, staff failed to comply with the home's Policy #6.665 titled "Storage of Narcotic/Controlled Drugs", last revised May 15, 2019.

A. A Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care (MOLTC), related to a controlled substance being missing for an identified resident. The CIS documented that on a specific date, during narcotic count at morning shift change, a discrepancy was noted with one capsule of a narcotic missing for the resident.

Physician's orders for the resident were reviewed and indicated that they were to receive one capsule of the narcotic by mouth two times a day at specific times.

The electronic Medication Administration Record (eMAR) was reviewed and indicated that administering RPN documented that one capsule of the narcotic was given to the resident at the prescribed time.

An Incident Report was completed by two Registered Practical Nurses (RPNs) at afternoon shift change when the discrepancy was discovered. It was documented that while doing the narcotic count in the afternoon, the numbers did not match for the identified resident's prescribed narcotic and that the discrepancy had occurred during the morning narcotic count, however, it had not been caught at that time. It was also documented on the report that two bubbles had been popped out from the medication card and signed by the RPN who administered the medication to the resident. The RPN who administered the medication to the resident denied administering two doses to the resident. The missing medication was searched for during the home's investigation and was never found.

The Incident Report that was completed in relation to the missing narcotic for the resident further documented that the cause of the incident was that the two RPNs who completed the narcotic count at shift change in the morning did not follow best practice guidelines and missed the discrepancy. Specifically, it stated that the number of narcotics remaining in the medication card was pre-filled by the outgoing RPN and that the outgoing RPN, who was responsible for recording the numbers on the narcotic sheet, counted the narcotics, and oncoming RPN, who was responsible for counting the narcotics, recorded the numbers on the narcotic sheet without looking at the medication card.

The identified resident's progress notes were reviewed in Point Click Care (PPC) related to this incident. A progress note was documented stating that the resident had woken up late that day and that the resident reported feeling unwell and fatigued. It was also documented that the resident declined to eat that day. A Nurse Practitioner (NP) assessed the resident and charted that staff were to continue to monitor the resident.

One of the RPNs completed a Practice Reflection Worksheet after the incident, which documented that during the narcotic count they completed with another RPN on the day the narcotic was found missing, the overhead light was not on, both RPNs were talking about the previous shift, the numbers on the narcotic card had been pre-filled and that they signed that the count was correct without visually observing the narcotic card.

The home's Policy #6.665 titled "Storage of Narcotic/Controlled Drugs", last revised May 15, 2019, was reviewed, and stated, in part, that "a physical inventory of all controlled medications will be conducted by two Registered staff at the end of each shift. The oncoming staff member will count the drugs while the outgoing staff member documents the count."

A Resident Care Coordinator (RCC) said, during an interview, that as a result of this incident, the home developed an audit tool called "Narcotic and Controlled Shift Count Audit". Inspector #741 reviewed five audits that the home completed within a one month time frame.

One of the RPNs resigned from the home shortly after the incident and was not available for an interview with Inspector #741 at the time of this inspection. The other RPN was contacted twice by phone by Inspector #741 for an interview, however, the Inspector was unable to reach them.

During an interview with the Manager of Resident Services (MRS), they said that the process for doing a narcotic count was for two Registered staff members to do the count together, with the oncoming staff member physically counting the narcotics and the outgoing staff member verifying the count. Both staff members would then sign and date the narcotic sheet together. The MRS said that it was unacceptable for Registered staff to pre-fill numbers and signatures on narcotic cards in advance of a narcotic count. They said that it was an expectation of the home that Registered staff follow the “Storage of Narcotic/Controlled Drugs” policy #6.665, last revised May 15, 2019, for narcotic counts and that the two RPNs failed to comply with it when they completed the narcotic count on the day there was a discrepancy in the count for the identified resident.

B. Inspector #741 reviewed an email that was provided to them by an RCC, in relation to the missing narcotic incident for the above mentioned identified resident. The email was sent by the MRS to all Registered staff and RCCs with high importance after the incident, and asked staff to review a policy that was attached related to controlled substances. The email stated, in part, “You must complete count with two Registered staff at the end of your shift, the oncoming nurse is to count the medications while the outgoing nurse documents the count”.

Inspector #741 observed a narcotic count at shift change on an identified date completed by an outgoing RPN and an oncoming RPN. It was observed that the outgoing RPN took the narcotic cards out of the narcotic box in the medication cart and counted each card out loud. The oncoming RPN was observed recording the numbers and did not look at every narcotic card. The dates and signatures were pre-filled by the outgoing RPN on the narcotic count sheet and the oncoming RPN signed during the count. After the narcotic count had concluded, the outgoing RPN stated that it was their practice to check through the narcotics and do a full narcotic count alone before the end of each of their shifts to avoid feeling overwhelmed during the actual narcotic count. They also said they pre-fill

the dates and their signature on the narcotic count sheets in advance of completing the narcotic count.

In an interview with the MRS, they said it was the home's expectation that staff not pre-fill signatures on the narcotic count sheet and that oncoming staff members take the narcotic cards out and count them while outgoing staff members verify the numbers, following which both staff members sign together. The MRS said the outgoing RPN and oncoming RPN did not follow the home's policy while doing the narcotic count on the identified date.

C. On an identified date, Inspector #741 observed the end of a narcotic count at shift change. The door to the medication room was open and two RPNs were observed loudly conversing while doing the narcotic count. Upon completion of the narcotic count, the outgoing RPN exited the medication room and the oncoming RPN was interviewed by Inspector #741. The RPN said that the process for doing narcotic count at shift change was that the outgoing RPN takes out the narcotic cards, reads out the numbers and shows the oncoming RPN the front and back of the cards to verify the numbers. They said that during the narcotic shift count that day, they had recorded the numbers on the narcotic count sheets.

The MRS said in an interview that bad practices had been adopted by Registered staff members when doing narcotic counts and that the practices were likely widespread throughout the home. They said that the outgoing RPN and the oncoming RPN who did the narcotic count together that day did not follow the home's policy for completing narcotic counts.

The licensee failed to ensure that Registered staff complied with the home's "Storage of Narcotic/Controlled Drugs" policy #6.665, last revised May 15, 2019 when completing narcotic counts.

The severity of this issue was determined to be a level one as there was no risk of harm as a result of this non-compliance. The scope of the issue was a level three as it was widespread in the home. The home had a level three compliance history as the home had previous non-compliance to the same subsection of the Long-Term Care Homes Act.

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents and that the policy was complied with.

The Ontario Regulation 79/10 defines "physical abuse" as:

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident

On a specific date during this inspection, Inspector #741 was in the Lakewood home area lounge, conducting an observation of an identified resident, related to different incident that was being inspected. A Registered Practical Nurse was observed working in the documentation room at that time, and several other residents were sitting in the lounge area. The resident was offered a snack by a Personal Support Worker (PSW), which they accepted and then followed another resident to a couch and sat down so they were facing each other. Less than a minute after the residents were seated, a brief verbal argument ensued, following which one resident hit the other resident multiple times on their shoulder with closed fists. The resident who had been hit was taken aback, pushed the other resident's arm away and asked them why they had done that. The PSW who was in the lounge intervened, separated the two residents and redirected the resident who was the aggressor to their room. The resident was seen walking down the hallway

on their own and the other resident remained in the lounge area. The PSW said they would need to check on the resident who was the redirected to their room and Inspector #741 left the home area.

The next day, Inspector #741 reviewed both identified residents' clinical records on Point Click Care (PCC) for follow-up actions regarding the altercation that was witnessed the previous day. The review indicated that there was no documentation of the incident, investigation or actions taken related to the incident.

The home's "Resident Abuse – Zero Tolerance for Abuse and Neglect" policy #6.045, last revised March 2020, was reviewed, and stated that all incidents of suspected or witnessed abuse of a resident must be reported and internally investigated. The policy also stated that examples of "physical abuse" included hitting pushing, biting, slapping, scratching, shaking, pinching, using force, kicking or handling the resident in a rough manner.

During an interview with the RPN who was observed working in the documentation room at the time of the incident, they said that if they witnessed or had suspicions that a resident had been abused, they would report the incident to the Registered Nurse (RN) immediately. They also said that they would be required to document the incident on Risk Management, notify the families, complete a head-to-toe assessment on the resident who was the recipient of the abuse and start a Dementia Observation System (DOS) if responsive behaviours contributed to the incident. When the RPN was asked about the altercation between the two identified residents the previous day, they said that had not witnessed the incident and that they were unaware that there had been any physical contact between the residents. They said that the PSW reported that one resident was being vocal with another resident and that they redirected the vocal resident away from the area. They said the incident should have been reported to them so they could have assessed the residents, notified families and completed the required documentation.

In an interview with the PSW who responded to the incident, they said that if they witnessed or suspected resident abuse they would report it to the RPN on duty immediately. They said that after the altercation between the two identified residents, they wrote the details of the incident down on a napkin but forgot to give it to the RPN. They said that they briefly told the RPN about the incident but did not provide all the details and that they should have. They also said that if a resident displayed responsive behaviours during their shift, they would be required to document the behaviours in Point of Care (POC). They said that that they should have documented the behaviours of the

resident who hit the other resident but did not.

During an interview with a Resident Care Coordinator (RCC), they said they became aware of the altercation between the two residents the day after the incident occurred. They stated that the PSW did not follow the home's policy to report resident abuse immediately and should have.

The licensee failed to ensure that staff complied with the home's "Resident Abuse – Zero Tolerance for Abuse and Neglect" policy #6.045, when a staff member did not immediately report the abuse of one resident by another resident.

Issued on this 31st day of July, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	AYESHA SARATHY (741)
Inspection No. / No de l’inspection :	2020_648741_0008
Log No. / No de registre :	004699-20, 006045-20, 006152-20, 007977-20, 009612-20, 009684-20, 009800-20, 013220-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 31, 2020
Licensee / Titulaire de permis :	County of Oxford 21 Reeve Street, WOODSTOCK, ON, N4S-7Y3
LTC Home / Foyer de SLD :	Woodingford Lodge - Woodstock 300 Juliana Drive, WOODSTOCK, ON, N4V-0A1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Mark Dager

To County of Oxford, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the Ontario Regulation 79/10.

Specifically;
A) The licensee must ensure that the home's "Storage of Narcotic/Controlled Drugs" policy is complied with.
B) The licensee must ensure that the narcotic shift count process is audited in each home area, at least monthly, and that documentation of the audits are kept in the home.
C) The licensee must ensure that all Registered Practical Nurses and Registered Nurses receive re-training related to the home's "Storage of Narcotic/Controlled Drugs" policy, specifically the process that pertains to conducting shift counts.
D) The licensee must keep records in the home that indicate that Registered Practical Nurses and Registered Nurses completed the re-training and the date of completion.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Act or Regulation required 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 plan, policy, protocol, procedure, strategy or system was complied with.

In accordance with O. Reg. 79/10, s. 114 (2), the licensee was required to have

written policies and protocols 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. Specifically, staff failed to comply with the home's Policy #6.665 titled "Storage of Narcotic/Controlled Drugs", last revised May 15, 2019.

A. On May 14, 2020, a Critical Incident System (CIS) #M632-000024-20 was submitted to the Ministry of Long-Term Care (MOLTC), related to a controlled substance being missing for resident #001. The CIS documented that on May 13, 2020, during the 1500 hours narcotic count at shift change, a discrepancy was noted with one capsule of Hydromorph Contin missing for the resident.

Physician's orders for resident #001 were reviewed and indicated that the resident was to receive one capsule of Hydromorph Contin 4.5mg by mouth two times a day at 0700 hours and 2000 hours.

The electronic Medication Administration Record (eMAR) was reviewed and indicated that RPN #111 administered one capsule of Hydromorph Contin 4.5 mg to resident #001 at 0647 hours on May 13, 2020.

An Incident Report was completed by Registered Practical Nurse (RPN) #129 and RPN #130 on May 13, 2020 when the discrepancy was discovered. RPN #130 documented that while doing the narcotic count at 1500 hours, it was found that the numbers did not match for Hydromorph Contin 4.5 mg for resident #001. They documented that the discrepancy had occurred during the morning narcotic count, however, it was not caught at that time. It was also documented on the report that two bubbles had been popped out from resident #001's narcotic card and signed by RPN #111. RPN #111 worked from 2300 hours on May 12, 2020 to 0700 hours on May 13, 2020 and denied administering two doses of Hydromorph Contin to resident #001 at 0700 hours. RPN #129 worked the 0700-1500 hours shift on May 13, 2020 and also denied administering one capsule of Hydromorph Contin to resident #001 during the day shift on May 13, 2020. The missing capsule of HM Contin was searched for during the home's investigation and was never found.

The Incident Report that was completed in relation to the missing narcotic for resident #001 further documented that the cause of the incident was that RPN

#111 and RPN #129 did not follow best practices when they completed the narcotic count at 0700 hours. Specifically, it stated that the number of narcotics remaining in the medication card was pre-filled by RPN #111 and that the outgoing RPN #111, who was responsible for recording the numbers on the narcotic sheet, counted the narcotics, and oncoming RPN #129, who was responsible for counting the narcotics, recorded the numbers on the narcotic sheet without looking at the medication card.

Resident #001's progress notes were reviewed in Point Click Care (PPC) related to this incident. On May 13, 2020 at 1351 hours, a progress note was documented stating that the resident had woken up for the day at 1340 hours and that they reported feeling unwell and fatigued. It was also documented that the resident declined to eat that day. Nurse Practitioner (NP) #131 assessed resident #001 and charted that staff were to continue to monitor the resident.

RPN #129 completed a Practice Reflection Worksheet on May 14, 2020, which documented that during the narcotic count at 0700 hours on May 13, 2020 the overhead light was not on, RPN #111 and RPN #129 were talking about the previous shift during the count, outgoing RPN #111 had pre-filled the numbers on the narcotic card and read out the numbers and that oncoming RPN #129 signed that the count was correct without visually observing the narcotic card.

The home's Policy #6.665 titled "Storage of Narcotic/Controlled Drugs", last revised May 15, 2019, was reviewed, and stated, in part, that "a physical inventory of all controlled medications will be conducted by two Registered staff at the end of each shift. The oncoming staff member will count the drugs while the outgoing staff member documents the count."

Resident Care Coordinator (RCC) #103 said, during an interview, that as a result of this incident, the home developed an audit tool called "Narcotic and Controlled Shift Count Audit". Inspector #741 reviewed five audits that the home completed from May 29, 2020 to June 27, 2020.

RPN #129 resigned from the home shortly after the incident and was not available for an interview with Inspector #741 at the time of this inspection. RPN #111 worked the night shift on two days during the course of the inspection and was contacted twice by phone by Inspector #741 for an interview, however, the

Inspector was unable to reach RPN #111.

During an interview with the Manager of Resident Services (MRS) #102, they said that the process for doing a narcotic count was for two Registered staff members to do the count together, with the oncoming staff member physically counting the narcotics and the outgoing staff member verifying the count. Both staff members would then sign and date the narcotic sheet together. MRS #102 said that it was unacceptable for Registered staff to pre-fill numbers and signatures on narcotic cards in advance of a narcotic count. They said that it was an expectation of the home that Registered staff follow the "Storage of Narcotic/Controlled Drugs" policy #6.665, last revised May 15, 2019, for narcotic counts and that RPN #111 and RN #129 failed to comply with it.

B. Inspector #741 reviewed an email that was provided to them by RCC #103, in relation to the missing narcotic incident for resident #001 on May 13, 2020. The email was sent by MRS #102 to all Registered staff and RCCs with high importance on May 21, 2020, and asked staff to review a policy that was attached related to controlled substances. The email stated, in part, "You must complete count with two Registered staff at the end of your shift, the oncoming nurse is to count the medications while the outgoing nurse documents the count".

Inspector #741 observed a narcotic count at shift change on July 15, 2020 at 1445 hours, completed by outgoing RPN #108 and oncoming RPN #109. It was observed RPN #108 took the narcotic cards out of the narcotic box in the medication cart and counted each card out loud. RPN #109 was observed recording the numbers and did not look at every narcotic card. The dates and signatures were pre-filled by RPN #108 on the narcotic count sheet and RPN #109 signed during the count. After the narcotic count had concluded, RPN #108 stated that it was their practice to check through the narcotics and do a full narcotic count alone before the end of each of their shifts to avoid feeling overwhelmed during the actual narcotic count. They also said they pre-fill the dates and their signature on the narcotic count sheets in advance of completing the narcotic count.

In an interview with MRS #102, they said it was the home's expectation that staff not pre-fill signatures on the narcotic count sheet and that oncoming staff

members take the narcotic cards out and count them while outgoing staff members verify the numbers, following which both staff members sign together. MRS #102 said RPN #108 and RPN #109 did not follow the home's policy while doing the narcotic count on July 15, 2020.

C. On July 15, 2020 at 1510 hours, Inspector #741 observed the end of a narcotic count at shift change. The door to the medication room was open and two RPNs were observed loudly conversing while doing the narcotic count. Upon completion of the narcotic count, the outgoing RPN exited the medication room and oncoming RPN #110 was interviewed by Inspector #741. RPN #110 said that the process for doing narcotic count at shift change was that the outgoing RPN takes out the narcotic cards, reads out the numbers and shows the oncoming RPN the front and back of the cards to verify the numbers. They said that during the 1500 hours shift count that day, they had recorded the numbers on the narcotic count sheets.

MRS #102 said in an interview that bad practices had been adopted by Registered staff members when doing narcotic counts and that the practices were likely widespread throughout the home. They said that RPN #110 and the outgoing RPN who did the narcotic count together on July 15, 2020 did not follow the home's policy for completing narcotic counts.

The licensee failed to ensure that Registered staff complied with the home's "Storage of Narcotic/Controlled Drugs" policy #6.665, last revised May 15, 2019 when completing narcotic counts.

The severity of this issue was determined to be a level one as there was no risk of harm as a result of this non-compliance. The scope of the issue was a level three as it was widespread in the home. The home had a level three compliance history as the home had previous non-compliance to the same subsection of the Long-Term Care Homes Act for which a VPC was issued. (741)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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:

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 31st day of July, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ayesha Sarathy

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