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

Amended Public Copy/Copie modifiée 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
Jan 05, 2022	2021_928577_0002 (A1)	012314-21, 012409-21, 013063-21, 013740-21, 013741-21, 014063-21, 014101-21, 014186-21, 014792-21, 014846-21, 015227-21, 015337-21, 015721-21, 016045-21, 016704-21, 016822-21, 017305-21	Critical Incident System

Licensee/Titulaire de permis

Henley Place Limited
200 Ronson Drive Suite 305 Toronto ON M9W 5Z9

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

Henley Place
1961 Cedarhollow Boulevard London ON N5X 0K2

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee requires additional time to achieve compliance. CDD changed to February 11, 2022.

Issued on this 5 th day of January, 2022 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

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

Amended by DEBBIE WARPULA (577) - (A1)

Amended 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): October 18 to 22, 25 to 29, and November 1 to 4, 2021.

The following intakes were inspected on during this Critical Incident System (CIS) inspection:

-one intake related to CIS #3045-000051-21, related to alleged neglect of a resident;

-one intake related to CIS #3045-000053-21, related to a resident fall with a fracture;

-one intake related to CIS #3045-000061-21, related to a resident fall with injury;

-one intake related to CIS #3045-000066-21, related to a resident fracture;

-one intake related to CIS #3045-000065-21, related to a resident fall with a fracture;

-one intake related to CIS #3045-000068-21, related to an alleged improper transfer of a resident;

-one intake related to CIS #3045-000073-21, related to concerns with the home's hot water system;

-one intake related to CIS #3045-000075-21, related to an unexpected resident death;

-one intake related to CIS #3045-000079-21, related to alleged staff to resident sexual abuse;

-one intake related to CIS #3045-000080-21, related to a resident fall;

-one intake related to CIS #3045-000087-21, related to a missing controlled substance;

-one intake related to CIS #3045-000089-21, related to a medication administration;

-one intake related to CIS #3045-000094-21, related to a fire in the home;

-one intake related to CIS #3045-000095-21, related to a delay of a resident transfer to the hospital;

-one intake related to CIS #3045-000100-21, related to a resident fall with injury;

-one intake related to CIS #3045-000104-21, related to a resident fall with injury; and

-one intake related to CIS #3045-000108-21, related to an emergency response during a fire.

Follow Up inspection #2021_928577_0004, and Complaint Inspection #2021_928577_0003 were conducted concurrently with this CIS inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (ADOC), Assistant Director of Care (ADOC), two Primacare Nursing Consultants, Registered Nurses (RNs), Registered Practical Nurses (RPNs) and the Consultant Geriatrx Pharmacist.

The Inspectors also conducted a daily tour of resident care areas, observed the

provision of care and services to residents, Infection Prevention and Control (IPAC) practices, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

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

- **3 WN(s)**
- **1 VPC(s)**
- **2 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 the Primacare and GeriatRx policies related to receiving, counting, storing and destroying controlled substances, included in

the required Medication Management Program, were complied with, for six residents.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols were 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.

O. Reg. 79/10, s. 133 requires that a drug record was established, maintained and kept in the home for at least two years, which recorded the following information, in respect of every drug that was ordered and received in the home: the date the drug was received in the home, the signature of the person acknowledging receipt of the drug on behalf of the home.

O. Reg 9/10, s. 136 (4) 2 requires that the drug destruction and disposal policy must provide that any controlled substance that was to be destroyed and disposed of should be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction occurred.

Specifically, staff did not comply with the Primacare policy “Ordering, Receiving, Recycling and Destruction” dated October 2015, the Primacare policy “Narcotics and Controlled Drugs" dated October 2015, the GeriatRx policy “Narcotic Prescriptions" dated September 1, 2015, and the GeriatRx policy "Medications for Destruction or Discharged Residents” dated May 11, 2020.

a) A resident was scheduled to receive a specific medication at two particular times. A Registered Nurse (RN) confirmed that they made a medication error and gave two specific dosages to the resident at a specific time. The RN said that at the end of their shift, they and the on-coming nurse had not counted the medication in the breakfast dose card during the shift count and assumed it was the same, therefore the error was not discovered at that time.

b) The Narcotic/Control Drug Tracking Sheet for a resident for a specific medication, under quantity remaining stated, “a specific count as of an identified date". On another identified date, entries were crossed out and “error” was written by a Registered Practical Nurse (RPN). On the back of the sheet a new entry dated for another identified date, with quantity remaining stated a specific amount, with a number of empty spaces and then entries of administration during the day

shift on an identified date, by the RPN. An RN and the RPN confirmed that there were actually no medications missing, and that the amount received was actually a specified amount of tablets in two cards, that both cards were documented on the same count sheet and there should be one sheet per card and that the count was incorrect. GeriatRx Pharmacist confirmed that the specific number of tablets of a specific medication in each of two separate cards were sent to the home on an identified date, and that there should be one count sheet per card of controlled medications.

c) GeriatRx Pharmacist said that the specific medication for a resident were delivered to the home at a specified time on an identified date, and were electronically scanned as received by a nurse a number of hours later. No pharmacy receipts for the specific medication for the resident could be found or produced. An RPN and Acting DOC confirmed that medications were delivered from the pharmacy in the evenings after 2000 hours and then were locked in the Medway medication room by the evening shift RN. The night shift RN then distributed the medications to each of the six units and the night nurses scanned the medications as received and started the count sheets. The RPN and Acting DOC agreed that this practice was not compliant with the home's policy and created risk for error with controlled substances.

d) Health records for a resident indicated that they passed away on an identified date. Primacare Nurse Consultant (NC) said that they discovered the discrepancy in the count of the resident's specific medication on an identified date. They said that the resident had already passed away and their specific medication were still in the narcotic bin in the medication cart along with other controlled substances for administration.

e) On an identified date, on a specific nursing unit, at the back of the narcotic bin in the medication cart, there was a divider labeled "D/C" with a card of a specific medication of a specific amount of half tablets, with D/C marked on the top for a resident. Assistant DOC confirmed that the resident was deceased and that the specific medication tablets for the resident should not have been in the narcotic bin with other medications for administration.

f) On an identified date, on another nursing unit, at the back of the narcotic bin in the medication cart, there was a medication card of a specific medication for a resident that had been discontinued on an identified date. There was a card of another specific medication for another resident, that had been discontinued on

an identified date, and there was a card of another specific medication for the resident that had been discontinued on an identified date. An RPN confirmed these medications were not supposed to be in the narcotic bin with medications for administration.

g) The Narcotic/Control Drug Tracking Sheet for a resident for a specific prescription number did not have the pharmacy label with all of the required information on it, including the date, quantity, strength or resident room number.

h) Every Narcotic Count sheet for a specific nursing unit for scheduled and PRN controlled substances dated for a specific month, did not have the peel off labels affixed to the angled section at the top of the columns, most were hand written in and did not include the prescription numbers. A specific number of sheets contained blank and/or crossed out rows and columns. A specific number of sheets had one entry and the rest of the page was crossed out and one had no date or time identified, but was signed by two staff members. A specific number of sheets included specified entries of a specific medication. Several entries had numbers crossed out, changed to a different number, or were illegible. A number of entries on different sheets included two numbers per count, and then changed to only one number in the following entry. Every Narcotic Count sheet for another nursing unit for scheduled and PRN controlled substances dated for a specific month, did not have the peel off labels affixed to the angled section at the top of the columns, most were hand written and did not include the prescription numbers. A specific number of sheets contained blank and/or crossed out rows and columns. A number of entries were not initialed or signed by two nurses. A number of entries on different sheets included two numbers per count, and then changed to only one number in the following entry. One sheet contained entries with three numbers in each entry. A specific number of entries were circled for an unknown reason.

Sources: Observations on three nursing units medication carts, narcotic bins and medication rooms, including individual and unit count sheets, Primacare policy Ordering, Receiving, Recycling and Destruction (dated October 2015), Primacare policy Narcotics and Controlled Drugs (dated October 2015), GeriatRx policy Narcotic Prescriptions (dated September 1, 2015), and Medications for Destruction or Discharged Residents (dated May 11, 2020), and staff interviews. [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to make a report in writing to the Director setting out the analysis and follow-up action, including the immediate actions taken to prevent recurrence, and the long-term actions planned, to correct a missing controlled substance and prevent recurrence.

a) The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) on an identified date, indicating that a specific number of

tablets of a specific medication for a resident were found to have gone missing on an identified date.

Primacare Nurse Consultant (NC) said on an identified date, they had discovered what looked like a specific number of doses of a specific medication went missing on an identified date, according to the individual controlled substance count sheet for a resident. They said they did not complete an investigation or analysis, did not speak to staff on shift at the time of the discrepancy, and were not sure what happened or who was involved; they gave the incident to the Executive Director (ED) to follow up. The ED said they received the CIS but had not followed up as they assumed the NC did the investigation, analysis and follow up actions.

An RN and an RPN said they were alerted to the discrepancy in the count on an identified date, and found there were no medications missing, but that the previous counts from a specific time period, were documented incorrectly; that the count indicated a specific number of tablets of a specific medication were received on an identified date, when only a specific number of tablets were received. Consultant Pharmacist confirmed that there were a specific number of tablets of a specific medication delivered to the home on an identified date, for the resident. Acting DOC and Primacare NC verified no investigation or analysis was completed related to the critical incident and that no follow up or action was completed related to the controlled substance counts not being completed as per policy or the incorrect documentation.

b) The home submitted a CIS report to the MLTC on an identified date, which indicated a missing tablet of a specific medication on an identified date for a resident. The CI indicated that an RN accidentally gave a specific number of tablets of a specific medication to a resident, completed a medication incident report and that education would be provided. The Assistant DOC said they interviewed the RN and said that the information in the CI was correct.

The medication incident report in risk management in Point Click Care (PCC), dated for an identified date, was completed by the RN, and stated they gave a specified amount of a specific medication to the resident at a specified time. The resident was scheduled to receive two specific doses at two specific times. The RN confirmed that they made a medication error and gave both doses to the resident at a specific time. The RN said that no one, including Assistant DOC interviewed them regarding the error.

Primacare NC and Acting DOC said they interviewed the RN after the inspector brought the discrepancy to their attention and determined that the critical incident report was incorrect and that Assistant DOC did not interview the RN and that an analysis of the incident and appropriate follow up action was not actually completed.

Sources: two Critical Incident System (CIS) reports, Individual controlled substance count sheets for two residents, controlled substance count sheets for two nursing units, health records for two residents, and staff interviews. [s. 107. (4) 4.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that a monthly audit was undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

The Acting DOC provided controlled substance count sheet audits completed over a specified time period, and said they could not find any others and was not able to speak to what was done about any discrepancies. Audits completed for a particular month on a specific nursing unit identified a specific number of discrepancies including a specific prescription number had discrepancy checked off as yes, with “missing ??” written beside it. Another Prescription number had discrepancy checked off as yes, with “an identified date prn medication missing?” written beside it. There was no documentation of any action taken related to the discrepancies.

Sources: Controlled substance count audits for four specific months, and staff interviews. [s. 130. 3.]

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 a monthly audit is undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered, to be implemented voluntarily.

Issued on this 5 th day of January, 2022 (A1)

[redacted]

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
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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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBBIE WARPULA (577) - (A1)
Inspection No. / No de l'inspection :	2021_928577_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	012314-21, 012409-21, 013063-21, 013740-21, 013741-21, 014063-21, 014101-21, 014186-21, 014792-21, 014846-21, 015227-21, 015337-21, 015721-21, 016045-21, 016704-21, 016822-21, 017305-21 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 05, 2022(A1)
Licensee / Titulaire de permis :	Henley Place Limited 200 Ronson Drive, Suite 305, Toronto, ON, M9W-5Z9
LTC Home / Foyer de SLD :	Henley Place 1961 Cedarhollow Boulevard, London, ON, N5X-0K2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Denise Bedard

To Henley Place Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 r. 8 (1) b of the O. Reg. 79/10

Specifically, the licensee must:
-educate all Registered staff on the home's medication policies, specific to receiving, counting, storing and destroying controlled substances
-maintain records of training including who attended the training and when it occurred
-DOC or designate will perform weekly audits of each medication cart to ensure that discontinued narcotics have been removed from the cart
-DOC or designate will perform weekly audits of the Narcotic/Control Drug Tracking sheet, to ensure proper documentation, including prescription numbers and labels
-DOC or designate will perform weekly audits of the narcotic record sheets to ensure narcotic counts are being done upon receiving narcotics from pharmacy, and at the beginning and end of each shift
-document audits, actions taken, and continue auditing until 30 consecutive days of adherence is achieved

Grounds / Motifs :

1. The licensee has failed to ensure the Primacare and GeriatRx policies related to receiving, counting, storing and destroying controlled substances, included in the

required Medication Management Program, were complied with, for six residents.

O. Reg. 79/10, s. 114 (2) requires that written policies and protocols were 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.

O. Reg. 79/10, s. 133 requires that a drug record was established, maintained and kept in the home for at least two years, which recorded the following information, in respect of every drug that was ordered and received in the home: the date the drug was received in the home, the signature of the person acknowledging receipt of the drug on behalf of the home.

O. Reg 9/10, s. 136 (4) 2 requires that the drug destruction and disposal policy must provide that any controlled substance that was to be destroyed and disposed of should be stored in a double-locked storage area within the home, separate from any controlled substance that was available for administration to a resident, until the destruction occurred.

Specifically, staff did not comply with the Primacare policy “Ordering, Receiving, Recycling and Destruction” dated October 2015, the Primacare policy “Narcotics and Controlled Drugs" dated October 2015, the GeriatRx policy “Narcotic Prescriptions" dated September 1, 2015, and the GeriatRx policy "Medications for Destruction or Discharged Residents” dated May 11, 2020.

a) A resident was scheduled to receive a specific medication at two particular times. A Registered Nurse (RN) confirmed that they made a medication error and gave two specific dosages to the resident at a specific time. The RN said that at the end of their shift, they and the on-coming nurse had not counted the medication in the breakfast dose card during the shift count and assumed it was the same, therefore the error was not discovered at that time.

b) The Narcotic/Control Drug Tracking Sheet for a resident for a specific medication, under quantity remaining stated, “a specific count as of an identified date". On another identified date, entries were crossed out and “error” was written by a Registered Practical Nurse (RPN). On the back of the sheet a new entry dated for another identified date, with quantity remaining stated a specific amount, with a

number of empty spaces and then entries of administration during the day shift on an identified date, by the RPN. An RN and the RPN confirmed that there were actually no medications missing, and that the amount received was actually a specified amount of tablets in two cards, that both cards were documented on the same count sheet and there should be one sheet per card and that the count was incorrect. GeriatRx Pharmacist confirmed that the specific number of tablets of a specific medication in each of two separate cards were sent to the home on an identified date, and that there should be one count sheet per card of controlled medications.

c) GeriatRx Pharmacist said that the specific medication for a resident were delivered to the home at a specified time on an identified date, and were electronically scanned as received by a nurse a number of hours later. No pharmacy receipts for the specific medication for the resident could be found or produced. An RPN and Acting DOC confirmed that medications were delivered from the pharmacy in the evenings after 2000 hours and then were locked in the Medway medication room by the evening shift RN. The night shift RN then distributed the medications to each of the six units and the night nurses scanned the medications as received and started the count sheets. The RPN and Acting DOC agreed that this practice was not compliant with the home's policy and created risk for error with controlled substances.

d) Health records for a resident indicated that they passed away on an identified date. Primacare Nurse Consultant (NC) said that they discovered the discrepancy in the count of the resident's specific medication on an identified date. They said that the resident had already passed away and their specific medication were still in the narcotic bin in the medication cart along with other controlled substances for administration.

e) On an identified date, on a specific nursing unit, at the back of the narcotic bin in the medication cart, there was a divider labeled "D/C" with a card of a specific medication of a specific amount of half tablets, with D/C marked on the top for a resident. Assistant DOC confirmed that the resident was deceased and that the specific medication tablets for the resident should not have been in the narcotic bin with other medications for administration.

f) On an identified date, on another nursing unit, at the back of the narcotic bin in the medication cart, there was a medication card of a specific medication for a

resident that had been discontinued on an identified date. There was a card of another specific medication for another resident, that had been discontinued on an identified date, and there was a card of another specific medication for the resident that had been discontinued on an identified date. An RPN confirmed these medications were not supposed to be in the narcotic bin with medications for administration.

g) The Narcotic/Control Drug Tracking Sheet for a resident for a specific prescription number did not have the pharmacy label with all of the required information on it, including the date, quantity, strength or resident room number.

h) Every Narcotic Count sheet for a specific nursing unit for scheduled and PRN controlled substances dated for a specific month, did not have the peel off labels affixed to the angled section at the top of the columns, most were hand written in and did not include the prescription numbers. A specific number of sheets contained blank and/or crossed out rows and columns. A specific number of sheets had one entry and the rest of the page was crossed out and one had no date or time identified, but was signed by two staff members. A specific number of sheets included specified entries of a specific medication. Several entries had numbers crossed out, changed to a different number, or were illegible. A number of entries on different sheets included two numbers per count, and then changed to only one number in the following entry. Every Narcotic Count sheet for another nursing unit for scheduled and PRN controlled substances dated for a specific month, did not have the peel off labels affixed to the angled section at the top of the columns, most were hand written and did not include the prescription numbers. A specific number of sheets contained blank and/or crossed out rows and columns. A number of entries were not initialed or signed by two nurses. A number of entries on different sheets included two numbers per count, and then changed to only one number in the following entry. One sheet contained entries with three numbers in each entry. A specific number of entries were circled for an unknown reason.

Sources: Observations on three nursing units medication carts, narcotic bins and medication rooms, including individual and unit count sheets, Primacare policy Ordering, Receiving, Recycling and Destruction (dated October 2015), Primacare policy Narcotics and Controlled Drugs (dated October 2015), GeriatRx policy Narcotic Prescriptions (dated September 1, 2015), and Medications for Destruction or Discharged Residents (dated May 11, 2020), and staff interviews. [s. 8. (1) (b)]

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

An order was made by taking the following factors into account:

Severity: There was no harm to residents.

Scope: The scope of this non-compliance was widespread as many staff were not following four medication policies related to receiving, counting, storing and destroying controlled substances.

Compliance History: The licensee was found to be non-compliant with r. 8 (1) b of O. Reg. 79/10 in the past 36 months, and a Compliance Order (CO) and a Voluntary Plan of Correction (VPC) was issued in the home. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 11, 2022(A1)

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: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
2. A description of the individuals involved in the incident, including,
i. names of any 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.
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
5. The name and title of the person who made the initial report to the Director under subsection (1) or (3), the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 107 (4).

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 / Ordre :

The licensee must be compliant with r. 107. (4) 4 of the O. Reg. 79/10

Specifically, the licensee must:
-develop and implement a process, including who is responsible, for ensuring the required documentation and investigation of Critical Incidents. Specifically, the investigation, analysis, immediate actions that have been taken to prevent recurrence, and long term actions to correct the situation and prevent recurrence

Grounds / Motifs :

1. The licensee has failed to make a report in writing to the Director setting out the analysis and follow-up action, including the immediate actions taken to prevent recurrence, and the long-term actions planned, to correct a missing controlled substance and prevent recurrence.

a) The home submitted a Critical Incident System (CIS) report to the Ministry of Long-Term Care (MLTC) on an identified date, indicating that a specific number of tablets of a specific medication for a resident were found to have gone missing on an identified date.

Primacare Nurse Consultant (NC) said on an identified date, they had discovered what looked like a specific number of doses of a specific medication went missing on an identified date, according to the individual controlled substance count sheet for a resident. They said they did not complete an investigation or analysis, did not speak to staff on shift at the time of the discrepancy, and were not sure what happened or who was involved; they gave the incident to the Executive Director (ED) to follow up. The ED said they received the CIS but had not followed up as they assumed the NC did the investigation, analysis and follow up actions.

An RN and an RPN said they were alerted to the discrepancy in the count on an identified date, and found there were no medications missing, but that the previous counts from a specific time period, were documented incorrectly; that the count indicated a specific number of tablets of a specific medication were received on an identified date, when only a specific number of tablets were received. Consultant Pharmacist confirmed that there were a specific number of tablets of a specific

medication delivered to the home on an identified date, for the resident. Acting DOC and Primacare NC verified no investigation or analysis was completed related to the critical incident and that no follow up or action was completed related to the controlled substance counts not being completed as per policy or the incorrect documentation.

b) The home submitted a CIS report to the MLTC on an identified date, which indicated a missing tablet of a specific medication on an identified date for a resident. The CI indicated that an RN accidentally gave a specific number of tablets of a specific medication to a resident, completed a medication incident report and that education would be provided. The Assistant DOC said they interviewed the RN and said that the information in the CI was correct.

The medication incident report in risk management in Point Click Care (PCC), dated for an identified date, was completed by the RN, and stated they gave a specified amount of a specific medication to the resident at a specified time. The resident was scheduled to receive two specific doses at two specific times. The RN confirmed that they made a medication error and gave both doses to the resident at a specific time. The RN said that no one, including Assistant DOC interviewed them regarding the error.

Primacare NC and Acting DOC said they interviewed the RN after the inspector brought the discrepancy to their attention and determined that the critical incident report was incorrect and that Assistant DOC did not interview the RN and that an analysis of the incident and appropriate follow up action was not actually completed.

Sources: two Critical Incident System (CIS) reports, Individual controlled substance count sheets for two residents, controlled substance count sheets for two nursing units, health records for two residents, and staff interviews. [s. 107. (4) 4.]

An order was made by taking the following factors into account:

Severity: There was minimal risk of harm to residents.

Scope: The scope of this non-compliance was a pattern as two Critical Incidents had no investigation or analysis completed and no follow up or action was completed.

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

Compliance History: The licensee was previously found to be in non-compliance with different sections of the legislation in the past 36 months. (213)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 22, 2021

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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

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

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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.

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 5 th day of January, 2022 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : Amended by DEBBIE WARPULA (577) - (A1)

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

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