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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2018	2018_735659_0013	011749-18	Critical Incident System

Licensee/Titulaire de permis

Southampton Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Southampton Care Centre
140 Grey Street P.O. Box 790 Southampton ON N0H 2L0

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

JANETM EVANS (659)

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): June 13 and 15, 2018.

The following intakes were completed:
Log #011749-18\Critical Incident #2597-000015-18 related to missing/unaccounted controlled substance.
Log #010761-18\Critical Incident #2597-000013-18 related to missing/unaccounted controlled substance.

During the course of the inspection, the inspector(s) spoke with the Administrator, Co-Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, residents and a Substitute Decision Maker.

The inspector conducted a brief tour of the home and made observations of residents and staff interactions, provision of care, medication storage areas and medication administration. Relevant clinical records for identified residents, policies and procedures, training, audits and staffing schedules were reviewed.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Medication
Pain
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 drugs are stored in an area or a medication cart, that is secure and locked.

When walking down the hall with the Co-Director of Care (Co-DOC) the medication cart was observed in the hall unlocked and unattended with residents in the immediate area.

The Co-DOC immediately locked the medication cart and stated the expectation was the medication cart was to be locked when staff were not in attendance.

The licensee failed to ensure that drugs were stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there is an allowable exception to this requirement.

Review of the Registered Nurse (RN) staffing schedules for a ten week period showed 31% of the time the home had used an agency RN to cover the RN shift.

Review of email documentation showed recruitment efforts for RN positions were ongoing between January to August 2018.

The Co-Director of Care (Co-DOC) said there had always been an RN in the building.

The Co-DOC and the Administrator acknowledged despite recruitment efforts there were times when the home did not have at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty in the home.

The licensee had failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement. [s. 8. (3)]

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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Two Critical Incident System reports (CI) alleged missing specified narcotic medication for two identified residents.

Review of the records for an identified resident documented the resident had been administered three doses of a specified narcotic medication on the evening shift of a specified date.

Review of the LTC Controlled Substance Administration Record for the identified resident documented that a partial vial of the specified narcotic medication was administered each time but there was no wastage documented or witnessed for two of the instances of the narcotic medication administration. There were two partial vials of the specified narcotic medication that were allegedly unaccounted for.

Review of the Medication Incident report showed there was a six day delay between when the alleged narcotic medication incident occurred and when the Registered Practical Nurse (RPN) notified the Co-Director Of Care (Co-DOC) of the alleged missing narcotic medication.

A RPN acknowledged co-signing for one of the narcotic medication wastage and stated there should have been more wastage to complete with the two registered staff then what had been signed for. The RPN acknowledged a delay in reporting the narcotic medication incident for the alleged two missing vials of the specified narcotic medication.

Review of the records for a second identified resident documented on a specified date the identified resident had been administered two scheduled doses of a specified narcotic and one as needed (prn) dose of the specified narcotic medication.

Review of the LTC Controlled Substance Administration Records showed on the specified date at a specified time time there should have been one dose of the narcotic medication remaining for the identified resident but it had been documented there was "0" left.

Review of the Medication incident report identified the RPN did not notify anyone at the time of discovering the missing specified narcotic medication. The missing specified narcotic medication was reported to the Co-Director of Care four days after the incident the incident was discovered to have occurred.

A RPN acknowledged they had not notified anyone of the missing dose of the specified narcotic medication at the time of the incident and stated they should have notified the RN.

Review of the LTC Controlled Substance Administration Records showed the practice of some registered staff of the home was to use a single use vial of narcotic medication to administer multiple doses of narcotic medication to a resident. One RN and three RPN stated they would either lock the remainder of the narcotic/controlled substance in the top drawer of the medication cart or put it on the counter in the locked medication room until they needed it for a second dose. Two of four registered staff stated that they were not familiar with the home's policy. All four registered staff were aware to notify their manager of missing narcotic/controlled medication.

The Co-Director of Care (Co-DOC) and Administrator said that when a medication incident was discovered the staff was to complete an incident report and give it to the DOC or Co-DOC to initiate an investigation.

The Co-DOC and Administrator said they had not been aware that single dose vials of narcotic medication were being utilized to administer multiple doses of narcotic medication to residents; they stated that the expectation for wasting medication from the single use vial of narcotic medication was that the unused portion of the medication should be disposed of and witnessed by two registered staff.

The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or

system instituted or otherwise put in place was complied with. Specifically staff failed to follow their procedure Medication Management System – Narcotics and Controlled Substances to immediately notify the Director of Care in the event of missing and or misappropriated narcotics or controlled substances, or inaccurate narcotic counts and staff failed to follow their procedure for Drug Disposal and Wasting of Medications by not disposing of unused portions of broken ampules of controlled medication. [s. 8. (1) (b)]

Issued on this 14th day of September, 2018

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

Original report signed by the inspector.