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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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130 Dufferin Avenue 4th floor
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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 15, 2015	2015_171155_0009	003092-15	Critical Incident System

Licensee/Titulaire de permis

ST. JOSEPH'S HEALTH SYSTEM
574 Northcliffe Avenue DUNDAS ON L9H 7L9

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

ST JOSEPH'S HEALTH CENTRE, GUELPH
100 WESTMOUNT ROAD GUELPH ON N1H 5H8

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

SHARON PERRY (155), CAROLYN MCLEOD (614)

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): March 10, 16, April 16, 17 and 27, 2015.

During the course of the inspection, the inspector(s) spoke with Director of Care-Long Term Care, Assistant Director of Care, Pharmacist, Pharmacy Quality Improvement Nurse, and 3 Registered Practical Nurses.

The inspector(s) also toured two resident living areas; observed medication rooms; reviewed resident records; reviewed policies and procedures pertaining to the inspection; reviewed drug records; reviewed pharmacy audits; reviewed homes' report given to Guelph Police and to the College of Nurses of Ontario; and reviewed an employee file.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **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	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. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policies and protocols for the medication management system ensure the accurate acquisition, receipt, and storage of all drugs used in the home are implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

On February 10, 2015 the home received 30 tablets in a blister pack for resident #001. Upon receipt of the medication the Registered Practical Nurse (RPN) #100 created a Narcotic and Controlled Substance Administration Record indicating that 30 tablets had been received from pharmacy. At 2230 hours a count was done by RPN #100 who received the medication and by RPN #101 who was coming on to work night shift. On February 11, 2015 at 0630 hours a count was done by RPN #101 indicating that there were 30 tablets remaining but the RPN #102 coming on days did not sign this count. On February 11, 2015 at 1430 hours a count was done by the RPN #102 and by the RPN #100 coming on to work evenings and the count indicated that there were 14 tablets remaining.

On February 11, 2015 at 1610 hours resident #001 requested some medication. RPN #100 returned to the medication cart to get resident #001 their medication and remembered receiving 30 tablets for resident #001 on the evening shift of February 10, 2015. RPN #100 then noted that the Narcotic and Controlled Substance Administration Record was not the one that they had written on February 10, 2015 when they received 30 tablets. The Narcotic and Controlled Substance Administration Record that was in use was written by RPN #102 indicating there were 14 tablets remaining.

RPN #100 who noted this discrepancy immediately reported it to management. An investigation was initiated. The original Narcotic and Controlled Substance Administration Record was found torn in the container used for items that are to be shredded. It was found that 12 tablets were missing for resident #001.

The management and pharmacy immediately initiated an audit of all residents living in the same living area as resident #001 that received the same medication on an only as needed basis. This revealed the following medications were diverted between January 21, 2015 to February 11, 2015:
-Resident #001 was missing a total of 94 tablets
-Resident #004 was missing 68 tablets
-Resident #003 was missing 41.5 tablets

-Resident #007 was missing 45 tablets
-Resident #002 was missing 20 vials of injectable medication
-Resident #008 was missing 49 tablets

The investigation showed that RPN #102 had diverted medication by never completing a Narcotic and Controlled Substance Administration Record for blister packs/carded medications thus never having a count sheet initiated; by destroying pharmacy packing slips; and by creating new Narcotic and Controlled Substance Administration Records indicating a different quantity of medication at the top of the record.

RPN #102 had worked on another resident living area prior to January 21, 2015. Management selected two residents from this area that received medications on an as needed basis and did an audit that revealed the following medications were diverted:
-Resident #006 was missing 892 tablets over a 12 month period.
-Resident #005 was missing 1238 tablets over a 13 month period.

The investigation showed that RPN #102 had diverted these medications by never completing a Narcotic and Controlled Substance Administration Record for blister packs/carded medications thus never having a count sheet initiated; by destroying pharmacy packing slips; and by creating new Narcotic and Controlled Substance Administration Records indicating a different quantity of medication at the top of the record.

The home uses MediSystem pharmacy and utilizes their policies and procedures. The Policy titled Narcotic and Controlled Substances Administration Record (Index Number:04-07-10) dated June 23, 2014 states the following:
7. A daily count of all narcotics can be made on the narcotic and Controlled Substance Administration Record. A check of the balance-on-hand must be done by two nurses or care providers as per facility policy at the time of every shift change or as per facility policy. The count and each signature are recorded in the appropriate column on the Narcotic and Controlled Substance Administration Record.

The daily count of all narcotics being made on the Narcotic and Controlled Substance Administration Record and not on a separate Narcotic and Controlled Substances count sheet allowed for the Narcotic and Controlled Substance Administration Record to be destroyed by RPN #102 and a new count sheet started indicating a lesser amount of medication on hand. With there not being a separate Narcotic and Controlled Substance count sheet other registered staff had no other record to compare amount of narcotics

and controlled substances on hand.

Interview with two RPNs indicated that when they receive a narcotic or controlled substance from pharmacy and it does not come with a typed Narcotic and Controlled Substance Administration Record that includes the residents name, medication, date issued, directions, quantity and prescription number they hand write the Narcotic and Controlled Substance Administration Record and fill in the required information. Interview with the Pharmacist revealed that if all the narcotics and controlled substances were sent with the typed Narcotic and Controlled Substance Administration Record sheets and staff did not have access to hand writing them this may have made the diversion of the medications more difficult.

On April 27, 2015 the Director of Care-Long Term Care confirmed that the home had not implemented any changes to the policies and practices regarding the Narcotic and Controlled Substance Administration Record. The Director of Care-Long Term Care stated that they were considering implementing a separate narcotic and controlled count sheet but confirmed it has not been done. [s. 114. (3) (a)]

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 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 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.

On March 16, 2015 a review of the Monthly Narcotic Audit of Count Sheets for an identified resident living area revealed that for 2015 the audit has not been completed for the months of January and February. For the year 2014 the audit was not completed for 10/12 months as it was only completed in July and August 2014.
The Director of Care-Long Term Care confirmed that a monthly audit of the daily count sheets of controlled substances was not completed. [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 steps are taken to ensure the security of the drug supply, including the following:
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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 133. Drug record (ordering and receiving)
Every licensee of a long-term care home shall ensure that a drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
3. The name, strength and quantity of the drug.
4. The name of the place from which the drug is ordered.
5. The name of the resident for whom the drug is prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
9. Where applicable, the information required under subsection 136 (4). O. Reg. 79/10, s. 133.

Findings/Faits saillants :

1. The licensee has failed to ensure that a drug record is established, maintained and kept in the home for at least two years, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered.
2. The signature of the person placing the order.
7. The date the drug is received in the home.
8. The signature of the person acknowledging receipt of the drug on behalf of the home.

Review of a medication reorder sheet indicated that residents #004, #007, and #001 were each ordered 30 tablets of an identified medication. The drug record did not include the date the drugs were ordered, the signature of the person placing the order, the date the drug was received in the home or the signature of the person acknowledging receipt of the drug on behalf of the home.

Review of the medication reorder sheets for an identified resident living area for the

period of February 2 to February 12, 2015 revealed that there were 17 reorders of medications for residents living on this area. The drug record did not include the date the drugs were ordered, the signature of the person placing the order, the date the drug was received in the home or the signature of the person acknowledging receipt of the drug on behalf of the home.

Review of the medication reorder sheets for another identified resident living area for the period of February 2 to February 7, 2015 revealed that there were 18 reorders of medications for residents living on this area. The drug record did not include the date the drugs were ordered, the signature of the person placing the order, the date the drug was received in the home or the signature of the person acknowledging receipt of the drug on behalf of the home.

The Director of Care-Long Term Care indicated that they knew who ordered the medications by reviewing at the electronic records that showed the date and time the medication reorder sheet was faxed to the pharmacy. This could then be checked with the registered staff schedules to see who was working and that is how it was determined who ordered the medications.

The Director of Care-Long Term Care confirmed that a drug record was not established, in which the following information is recorded in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home.
[s. 133.]

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 drug record is established, maintained and kept in the home for at least two years, in which is recorded the following information, in respect of every drug that is ordered and received in the home:
1. The date the drug is ordered
2. The signature of the person placing the order
7. The date the drug is received in the home
8. The signature of the person acknowledging receipt of the drug on behalf of the home, to be implemented voluntarily.

Issued on this 15th day of June, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére de la Santé et 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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), CAROLYN MCLEOD (614)
Inspection No. / No de l'inspection :	2015_171155_0009
Log No. / Registre no:	003092-15
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 15, 2015
Licensee / Titulaire de permis :	ST. JOSEPH'S HEALTH SYSTEM 574 Northcliffe Avenue, DUNDAS, ON, L9H-7L9
LTC Home / Foyer de SLD :	ST JOSEPH'S HEALTH CENTRE, GUELPH 100 WESTMOUNT ROAD, GUELPH, ON, N1H-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	MARIANNE WALKER

To ST. JOSEPH'S HEALTH SYSTEM, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan for achieving compliance with O. Reg. 79/10, s. 114(3).

The plan must include what immediate and long term actions will be undertaken to correct the identified areas of non-compliance, as well as who will be responsible to correct the areas of non-compliance and the dates for completion.

Please submit the plan, in writing quoting log number 003092-15, to Sharon Perry, Long Term Care Homes Inspector-Nursing, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, by email, at Sharon.Perry@Ontario.ca by July 6, 2015.

Grounds / Motifs :

1. On February 10, 2015 the home received 30 tablets in a blister pack for resident #001. Upon receipt of the medication the Registered Practical Nurse (RPN) #100 created a Narcotic and Controlled Substance Administration Record indicating that 30 tablets had been received from pharmacy. At 2230 hours a count was done by RPN #100 who received the medication and by RPN #101 who was coming on to work night shift. On February 11, 2015 at 0630 hours a count was done by RPN #101 indicating that there were 30 tablets remaining but the RPN #102 coming on days did not sign this count. On

February 11, 2015 at 1430 hours a count was done by the RPN #102 and by the RPN #100 coming on to work evenings and the count indicated that there were 14 tablets remaining.

On February 11, 2015 at 1610 hours resident #001 requested some medication. RPN #100 returned to the medication cart to get resident #001 their medication and remembered receiving 30 tablets for resident #001 on the evening shift of February 10, 2015. RPN #100 then noted that the Narcotic and Controlled Substance Administration Record was not the one that they had written on February 10, 2015 when they received 30 tablets. The Narcotic and Controlled Substance Administration Record that was in use was written by RPN #102 indicating there were 14 tablets remaining.

RPN #100 who noted this discrepancy immediately reported it to management. An investigation was initiated. The original Narcotic and Controlled Substance Administration Record was found torn in the container used for items that are to be shredded. It was found that 12 tablets were missing for resident #001.

The management and pharmacy immediately initiated an audit of all residents living in the same living area as resident #001 that received the same medication on an only as needed basis. This revealed the following medications were diverted between January 21, 2015 to February 11, 2015:
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RPN #102 had worked on another resident living area prior to January 21, 2015. Management selected two residents from this area that received medications on an as needed basis and did an audit that revealed the following medications

were diverted:
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The daily count of all narcotics being made on the Narcotic and Controlled Substance Administration Record and not on a separate Narcotic and Controlled Substances count sheet allowed for the Narcotic and Controlled Substance Administration Record to be destroyed by RPN #102 and a new count sheet started indicating a lesser amount of medication on hand. With there not being a separate Narcotic and Controlled Substance count sheet other registered staff had no other record to compare amount of narcotics and controlled substances on hand.

Interview with two RPNs indicated that when they receive a narcotic or controlled substance from pharmacy and if it does not come with a typed Narcotic and Controlled Substance Administration Record that includes the residents name, medication, date issued, directions, quantity and prescription number they hand write the Narcotic and Controlled Substance Administration Record and fill in the required information. Interview with the Pharmacist revealed that if all the narcotics and controlled substances were sent with the typed Narcotic and Controlled Substance Administration Record sheets and staff

did not have access to hand writing them this may have made the diversion of the medications more difficult.

On April 27, 2015 the Director of Care-Long Term Care confirmed that the home had not implemented any changes to the policies and practices regarding the Narcotic and Controlled Substance Administration Record. The Director of Care-Long Term Care stated that they were considering implementing a separate narcotic and controlled count sheet but confirmed it has not been done.

The licensee has failed to ensure that the written policies and protocols for the medication management system ensure the accurate acquisition, receipt, and storage of all drugs used in the home are implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2015

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 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:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 15th day of June, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : SHARON PERRY

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