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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 31, 2019	2019_643111_0008	002477-18, 009513-18, 026347-18, 002331-19	Critical Incident System

Licensee/Titulaire de permis

Glen Hill Terrace Christian Homes Inc.
200 Glen Hill Drive South WHITBY ON L1N 9W2

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

Glen Hill Strathaven
264 King Street East Bowmanville ON L1C 1P9

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

LYNDA BROWN (111)

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): February 26, 27, 28, March 1, 4 to 8, 11-14, 18 and 20, 2019.

The following critical incidents related to missing/unaccounted controlled substances, were inspected concurrently during this inspection:
-Log #002331-19, Log #026347-18 and Log #009513
-Log #002477-18 was closed as per the bundling policy.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC) Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN) and Pharmacy Consultant.

During the course of the inspection, the inspector: observed residents, reviewed resident health care records, reviewed narcotic/controlled substances records, storage areas, reviewed employee records, reviewed staff training records, reviewed the Professional Advisory Committee (PAC) meeting minutes and reviewed the following licensee policies: Narcotic Counts & surplus Discontinued Narcotic and Controlled Medications. The following SmartMeds Pharmacy policies were also reviewed: Delivery of narcotic and Controlled Medications and Medication Incident Report.

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

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 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. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that every medication incident involving a resident was: (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, and the Medical Director.

A critical incident report was submitted to the Director on a specified date, for missing/unaccounted for narcotic and controlled substances. The CIR indicated on a specified date, RPN #133 discovered the narcotics for resident #005 had been tampered with by RPN #132 and the narcotics were unaccounted for. The CIR was amended on a later date to indicate resident #006, #007 and #008 also had missing/unaccounted for narcotic and/or controlled drugs.

Review of the licensee's policy on Medication Incident Report (9-1), revised April 2016, indicated that when a medication incident occurs, the registered staff are to record it on the medication incident report form and communicate it to proper authorities (e.g. DOC/ADOC/Physician/Pharmacy).

Review of the medication incident report form for resident #005, completed on a specified date, indicated RPN #133 discovered a specified number of a specified narcotic was missing and had been replaced with other medication. There was no evidence the Substitute Decision Maker (SDM) or the Medical Director (MD) were notified. The incident report was completed by the DOC.

Review of the progress notes for resident #005 during a specified period, indicated there was no documented evidence to indicate the immediate actions taken to assess and maintain the resident's health or to indicate the resident's SDM or the MD were notified.

During an interview with RPN #133 by Inspector #111, the RPN indicated on a specified date, they arrived for work at a specified time, to relieve RPN #132. RPN #133 indicated they witnessed RPN #132 at the medication cart, taping the back of one of the residents narcotic cards. RPN #133 indicated they then completed a narcotic shift count with RPN #132 and the count appeared correct. RPN #133 indicated when they checked the cards again, they noted the card with the tape on the back had a number of the narcotics replaced with different medication and immediately reported this to the DOC. The RPN confirmed they did not complete a medication incident report for this incident and could not recall if the SDM or the Medical Director were notified.

During an interview with the DOC by Inspector #111, they indicated the expectation was that any nurse who discovered a medication incident, including missing narcotic/controlled substances, was to complete the medication incident report form, notify the DOC, Physician, SDM and the Medical Director. The DOC confirmed a medication incident report was completed for resident #005 by the DOC after the RPN reported the incident to them. The DOC also confirmed the SDM and the Medical Director were not informed of the medication incident.

Review of the home's investigation and review of the health records of resident #006, #007, #008 and #00 for the large quantity of missing/unaccounted for narcotics and/or controlled substances indicated the following:
-Resident #006: review of the Medication Administration Records (MAR) and the Narcotic/Controlled substances records indicated there was multiple entries with inaccurate documentation of narcotics/controlled substances and borrowing the resident's narcotics for other residents completed by RPN #132.
-Resident #007: review of MAR and the Narcotic/Controlled substances records indicate there was inaccurate documentation completed, there was a large quantity of

narcotics/controlled substances administered during a specified period of time and there were multiple dates when RPN #132 was borrowing the resident's controlled substance, for other residents.
-Resident #008: had reported that RPN #132 had attempted to administer a non-narcotic analgesic instead of their prescribed narcotic which was witnessed by a family member.
-Resident #009: on a specified date, RPN #133 discovered that RPN #132 had documented on the narcotic record that they administered a few narcotics to the resident on a specified date and time, but there was no documentation in the MAR or in the resident's progress notes. The RPN confirmed with the resident that they had not received the drug and reported the incident to the DOC. Review of the progress notes for resident #009 confirmed the resident had been in pain. There was no evidence the resident's SDM or the MD were notified.
-There were no medication incident reports completed for resident #006, #007, #008 and #009, who had missing/unaccounted narcotics and/or controlled substances.

During an interview with RPN #133 by Inspector #111, the RPN confirmed they had discovered that on a specified date and time, RPN #132 had documented on the individual narcotic drug record sheet for resident #009, that they had administered narcotics to the resident but the resident denied ever receiving them and had been in pain. RPN #133 was unable to recall if a medication incident report was completed for this incident, or if they notified the resident's SDM or the MD. RPN #133 confirmed they reported the medication incident to the DOC, but was unable to recall when they notified the DOC.

During an interview with the DOC, the DOC indicated there was no medication incident reports completed for the missing/unaccounted controlled substances for resident #006, #007, #008 and #009. The DOC was unable to indicate when those medication incidents were discovered, but indicated they were discovered between a specified period of time, during the investigation. The DOC confirmed that the SDM's for resident's #006, #007 and #009 were not informed of the medication incidents. The DOC confirmed RPN #132 was also improperly documenting the administration of narcotics and controlled substances. The DOC indicated they determined that RPN #132 had signed as administering a large quantity of narcotics to resident #006, over a specified period but were unable to verify if the resident received them due to cognitive impairment. The DOC confirmed it was against the home's policy to borrow narcotics/controlled substances for other residents. The DOC indicated RPN #132 had signed as administering a large quantity of narcotics and controlled substances to resident #007, over a specified period and resident #007 denied receiving them. The DOC indicated resident #008 had

reported to the DOC on a specified date, that when they had requested their narcotic for pain, RPN#132 had attempted to give them a non-narcotic analgesic instead. The DOC indicated that RPN #133 had also reported that on a specified date, they had discovered RPN #132 had documented on resident #009's narcotic sheet a few day before, at a specified time, that they had administered a number of narcotics to the resident but the resident continued to have pain and had to be administered another dose a short time later by another RPN. The DOC indicated that RPN #133 confirmed with resident #009 that they had never received their narcotic from RPN #132 on the specified date and was in pain. The DOC confirmed there was no medication incident report completed for this medication incident that wasn't reported until a few days later. The DOC confirmed the Medical Director was not informed of any of the medication incidents involving resident #006, #007, #008 and #009. The DOC confirmed there were no documented evidence to indicate the residents were assessed or actions taken, for resident #006, #007 and #009, after the medication incidents were discovered.

The licensee has failed to ensure that every medication incident involving a resident was documented, as there were no medication incident reports completed for the medication incidents involving resident #006, #007, #008 and #009. The medication incidents involving resident #005 and #009 did not include a record of the immediate actions taken to assess and maintain the resident's health. The medication incidents involving resident #006, #007 and #009 were not reported to the resident's SDMs and the MD was not informed of the medication incidents, involving resident #006, #007, #008 and #009.

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

There were two separate critical incident reports submitted to the Director on two specified dates for missing/unaccounted narcotics and controlled substances . The first CIR indicated on a specified date, RPN #115 had discovered that RPN #132 had reordered and received a large number of narcotic and/or controlled substances for two different residents (resident #003 and #004), the drugs were unaccounted for and the police were notified.The Second CIR indicated RPN #132 no longer worked in the home.

Review of the health record for resident #003 indicated the resident had a diagnoses that caused a specified responsive behaviour and was prescribed an as needed (PRN) controlled drug.

Review of the health record for resident #004 indicated the resident had pain related diagnoses and was prescribed a PRN narcotic analgesic.

Review of the health care record for resident #005 indicated the resident had pain related diagnoses, had ongoing pain to specified areas and was prescribed a PRN narcotic analgesic.

Review of the health record for resident #006 indicated the resident had pain related and responsive behaviour related diagnoses. The resident was prescribed a PRN narcotic and PRN controlled drug.

Review of the health record for resident #007 indicated the resident was admitted with multiple pain related diagnoses and was prescribed both routine and PRN narcotic analgesics. The resident was also prescribed a PRN controlled drug for a responsive behaviour related diagnosis.

Review of the Narcotic Counts & Surplus Discontinued Narcotic and Controlled Medications policy (VI-J-10.46), revised on March 2018, indicated the RN/RPNs will: report any discrepancies over numbers of controlled substances/narcotics/PRN anxiolytics between shifts to the Director of Care immediately.The Director of Care will Investigate and respond to all discrepancies.

Review of the Ordering Narcotic and Controlled Medications policy (6-2) (reviewed September 2016), under Re-Orders, facility staff may re-order as per re-order procedure.

A review of the home's investigation by Inspector #111, indicated in addition to the missing/unaccounted narcotic and controlled substances involving RPN #132, there were also incidents when RPN #132 was noted to be excessively administering PRN narcotics/controlled substances or signing for narcotics, but not administering them to the residents.

During an interview with the DOC by Inspector #111, the DOC confirmed that RPN #132 had been reordering and receiving a large quantity of narcotics and controlled substances for resident #003 and #004 who were not in their care, and RPN #132 could not indicate why the narcotic/controlled substances were unaccounted for or included in the shift count when they were received by the RPN. The DOC confirmed no further

investigation or corrective actions were taken with RPN #132 after the first critical incident. The DOC indicated after the second critical incident, they again discovered that RPN #132 had been reordering narcotics and controlled substances for residents not in their care, RPN #132 continued to work and no investigation was completed until the following day. The DOC confirmed RPN #132 was not relieved of duty until the following day, when the RPN was found unfit to work. The DOC indicated after RPN #132 had left the home, they discovered that RPN #132 had tampered with narcotics that belonged to resident #005 and notified the police. The DOC indicated at that time, as part of their investigation, they complete an audit of all the narcotic/controlled substances and noted several dates where RPN #132 was reordering and receiving narcotic/controlled drugs and discovered there was a large quantity of missing/unaccounted for narcotics and controlled substances. The DOC indicated they also noted that RPN #132 had been documenting that they had been excessively administering narcotic and/or controlled substances to residents #006, #007 and #008 during a specified period on the unit they worked on. The DOC indicated as a result of the investigation, they confirmed a large quantity of narcotic and controlled substances were missing/unaccounted for, all involving RPN #132. The DOC indicated the licensee's reorder policy was updated to include that the registered nursing staff should only be reordering narcotics and controlled substances for residents that they are assigned to provide care.

During an interview with the Administrator, they confirmed RPN #132 no longer worked in the home as a result of the investigation into the missing/unaccounted for narcotic/controlled substance, after the second CIR was submitted. The Administrator confirmed the police and College of Nurses were also notified. The Administrator indicated RPN #132 was found reordering PRN narcotic and controlled substances for residents that were not in their care, receiving the narcotic/controlled substances but not including them in the narcotic shift count and documenting excessively administering PRN narcotic/ controlled substances to residents. The Administrator indicated they noted that the incidents of reordering/receiving of narcotics/controlled substances only occurred when RPN #132 was working a specified. The Administrator indicated during a later interview, that RPN #141 had confirmed awareness of RPN #132 excessively administering narcotics and controlled substances to residents on their unit, but did not report it.

There were eight residents (resident #003, #004, #005, #006, #007, #008, #009 and #010) involved in a large quantity of missing/unaccounted controlled substances, all involving RPN #132, over a specified period. The licensee failed to take corrective actions on a specified date, when narcotic/controlled substances were

missing/unaccounted for. In addition, the home failed to review and analyze a medication incident on a specified date, when the same RPN was involved, until the following day, after the RPN was found unfit to work. RPN #132 was allowed to continue to work, allowing further access to the narcotic/controlled substances on a specified date, where additional narcotic/controlled substances went missing. The RPN was then returned to work the following day, completed two narcotic shift counts, allowing additional access to the narcotic/controlled substances, and more narcotic/controlled substances were unaccounted for.

Additional Required Actions:

CO # - 001, 002 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. 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 any policy or protocol instituted, or otherwise put in place, was complied with.

Under O. Reg. 79/10, s.114 (2) The licensee shall ensure that written policies and protocols are 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.

Review of the Narcotic and Controlled Drug Count & Ward Count policy (6-6), reviewed

April 2016 indicated:
-Every narcotic and controlled drug order will come from the pharmacy with a Resident's Narcotic/Controlled Drug Count form which must be filed as per facility preference (e.g. Narcotic Binder). This count sheet must remain in the binder as long as the medication is active on the MAR. The count for every new narcotic or controlled drug order received must be added to the Narcotic Ward Drug Count form.
-The Resident's Narcotic/Controlled Drug Count form is used to monitor medication administration. The Narcotic Ward Drug Count form is used to document the physical count for narcotic and controlled medications at each shift change.
-Narcotic and controlled medications should always be double locked.
-To maintain an accurate record of physical counts, both nurses are required to verify the medications on hand against the Narcotic Ward Count form. Both nurses must be physically present during the entire count.

A critical incident report (CIR) was submitted to the Director on a specified date, for a controlled substance missing/unaccounted for. The CIR indicated on a specified date, RPN #132 had reordered and received a large quantity of narcotics/controlled substances for two different residents (resident #003 and #004) and the narcotics/controlled substances were never located.

A second critical incident report (CIR) was submitted to the Director on a specified date, for a controlled substance missing/unaccounted for. The CIR indicated there were a large quantity of missing/unaccounted narcotic and controlled substances, all involving RPN #132 and resident #005, #006, #007 and #008. The CIR was amended and indicated the home discovered RPN #132 had also been reordering and receiving narcotic controlled drugs.

Review of the home's investigation into both incidents indicated:
-on a specified date, RPN #132 had reordered and received a number of specified narcotics for resident #004 and a number of specified controlled substances for resident #003. RPN #132 had reordered the narcotics/controlled substances for the two residents, that were not in their care. Three days later, RPN #115 then reordered the same narcotic for resident #004 as the drugs were low. The following day, the pharmacy notified the home that the specified narcotic for resident #004 had already been previously ordered and received four days earlier, by RPN #132 but that were unaccounted for. RPN #115 then immediately reported the missing narcotics to the DOC.The DOC interviewed RPN #132, who confirmed they had reordered and received the narcotic/controlled drugs, but could not indicate what happened to the narcotics/controlled drugs for resident #003 and

#004, or why they were not included in the narcotic ward drug count when they were received. RPN #132 informed the DOC they were reordering the controlled substances for the unit on which they were scheduled to work the double shift.
-On a specified date, RPN #132 had reordered and received a number of a specified narcotic for resident #009 that was not in their care. Although these drugs were accounted for, RPN #132 had indicated they administered a dose of the specified narcotic to the resident that same date, but the resident denied ever receiving the drug and indicated the RPN had attempted to administer a non-narcotic analgesic instead.
There was a review completed by the DOC for all of the dates that RPN #132 had worked on specified shifts and noted a number of dates, when the RPN had been noted to be reordering/receiving narcotics and/or controlled substances for residents not in their care and discovered a large quantity of narcotic/controlled substances were unaccounted, for resident #003, #004 and #010.
- The DOC indicated that on one of the dates the narcotic/controlled substances were reordered and received, they discovered the drugs had been reordered too early and the pharmacy failed to notify the home.
-RPN #132 no longer works in the home.

During an interview with the DOC, they indicated the medication policy was revised to have two separate forms completed for any narcotic/controlled drugs used in the home, one for an individual narcotic/controlled drug sheet and a second for the shift/ward count. The DOC indicated all registered staff were retrained on the policy changes after the first incident.

The licensee failed to ensure the Narcotic and Controlled Drug Count & Ward Count policy was complied with, as RPN #132 had received narcotic and controlled drugs for resident #003, #004 and #010 and the drugs were never included in the ward count.

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 the written policy, protocol that is developed for the medication management system is complied with related to ensuring accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs in the home, to be implemented voluntarily.

WN #3: 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 :

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

A critical incident report (CIR) was submitted to the Director on a specified date, for a controlled substance missing/unaccounted for. The CIR indicated on a specified date and time, the narcotic drug destruction was being completed by the Pharmacist and DOC when they both discovered that a number of narcotic and/or controlled drugs were missing from the drug destruction container. The CIR indicated the drugs had been

discontinued on a specified date (by RPN #115 and RN #138) and the following day (by RPN #139 and RN #140). The CIR indicated the home was unable to locate the controlled substances and the police were notified.

During an interview with RPN #126, RN #119 and RN #131, they all indicated the process for discontinuing a controlled substance included, the RN and RPN would sign off the discontinued controlled substance on both the individual and ward count sheet, then both staff take the individual count sheet and the discontinued controlled substances to the double-locked area on the second floor. They all indicated that both staff would then witness the drugs being placed into the locked drug destruction container, both staff signed the drug destruction form, that included the resident's name, drug, amount and prescription number. They all confirmed that only the RNs, ADOC and DOC had the key to the narcotic/controlled drug destruction room and only the pharmacy had access to the locked drug destruction container. RN #131 indicated that previously, not all of the RN's were following the proper practise or drug destruction, as some RNs would just bring the drug destruction sheet down to the RPN to sign off and then take the controlled drugs by themselves, back to the drug destruction locked area. RN #131 also indicated that the home previously had a smaller, portable, drug destruction container which would quickly become too full and registered staff would have to call the ADOC to have the container emptied.

During an interview with RPN #115, they indicated that previously, when the smaller narcotic/controlled drug destruction container was in place and the container was too full, they could see the narcotic/controlled substances cards sticking out of the container. The RPN denied giving any narcotic/controlled substances directly to the RN to be destroyed and always made sure they went with the RN to the locked drug destruction room, to ensure that they were properly disposed of, as it was their signature that was also on the form.

During an interview with the DOC, they confirmed that only the DOC, ADOC and RN Supervisor's had a key to the narcotic/controlled substance drug destruction room. The DOC indicated the Pharmacist only had the key to the drug destruction container. The DOC indicated that RN #138 and #140, who placed the narcotic/controlled substances in the narcotic/controlled substance drug destruction room, no longer work in the home. The DOC indicated they were unable to determine who was directly involved in the missing narcotic/controlled drugs. The DOC indicated the incident has not occurred since the new, larger container was put in place.

During an interview with the Pharmacist by Inspector #111, the Pharmacist indicated when the pharmacy services were started in the home, they provided a smaller, locked, portable container for drug destruction of narcotic/controlled substances. The Pharmacist indicated on a specified date, they came to the home to complete the narcotic/controlled substances drug destruction with the nurse manager, they discovered that there were narcotic/controlled drugs recorded on the drug destruction form and not located in the drug destruction container. The Pharmacist indicated they determined the drugs went missing because the bin was too small and overflowing, which allowed access to the discontinued narcotics/controlled drugs. The Pharmacist indicated the drug destruction container was then changed to a larger stationary container as a result.

Review of the home's investigation, when the new pharmacy provider started in the home, a small movable, but locked container was provided to dispose of the narcotics/controlled substances. An RN reported that they had called the pharmacy to have the narcotic drug destruction container emptied six days before the Narcotics/controlled substances were discovered missing. The home discovered that the narcotic/controlled drug destruction container was too small and not able to safely contain the discontinued narcotics/controlled substances. The larger, immovable and locked container was put in placed two weeks after the narcotic/controlled substances were discovered missing from the drug destruction container.

During an interview with the Administrator, they confirmed that some of the RNs were not following the correct procedures around disposing of narcotic/controlled substances and ensuring the key for the narcotic/controlled drug destruction room was kept in a safe location. The Administrator indicated the actions taken to prevent a recurrence included, the drug destruction container was changed to a larger, stationary one and the policy for the procedure was changed.

The licensee had failed to ensure that narcotic/controlled substances were stored in a separate, double-locked, stationary cupboard in the locked area.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that controlled substances are stored in a separate, double-locked stationary cupboard, in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: 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:
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.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the report in writing to the Director, of a missing/unaccounted controlled substance included a description of the incident and the events leading up to the incident.

A critical incident report (CIR) was submitted to the Director on a specified date, for a missing/unaccounted controlled substance. The CIR indicated on a specified date and time, RN #134 reported to the DOC of concerns with RPN #132. RPN #132 was relieved of duty and a narcotic count was completed with RPN #133. RPN #133 observed RPN #132 with resident #005's narcotic card, prior to the count. RPN #133 later discovered the narcotic card for resident #005 had been tampered with. The CIR was amended and indicated there were additional residents (#006, #007 and #008) with missing/unaccounted controlled substances involving RPN #132.

Review of the home's investigation into the missing/unaccounted for controlled substances indicated:
-RPN #133 had reported to the DOC the day before the CIR was submitted, that RPN #132 had reordered narcotics for resident #009 that was not in their care.
-RPN #133 had also reported on a specified date, that they noted RPN #132 had signed as administering a specified dose of narcotics on the resident narcotic/controlled substances drug record, at a specified time, to resident #009, the day before the CIR was submitted. RPN #132 did not document on the MAR or in the residents' progress notes, to indicate why the drug was given and/or effectiveness. RPN #133 also noted that another RPN had administered the same narcotic a few hours after RPN #132, for the same drug, to resident #009 as the resident's progress notes indicating the resident had complained of pain to a specified area. RPN #133 indicated when they asked resident #009 if they had received any analgesic on the specified date/time by RPN #132, the resident confirmed they only received the specified narcotic by a different RPN.

During an interview with the DOC by Inspector #111, the DOC confirmed that on the day before the CIR was submitted, RPN #133 had reported to the DOC that they had discovered RPN #132 reordering narcotics for residents on a different unit, whom RPN #132 was not providing care. The DOC also confirmed awareness that during the home's investigation, RPN #133 had also reported that RPN #132 had signed for a narcotic as administered to resident #009, but confirmed the resident never received the narcotic by RPN #132 and confirmed this was not indicated on the CIR.

The licensee failed to ensure the report in writing to the Director of a missing/unaccounted controlled substances, included a description of all the incidents and the events leading up to the incidents, as the CIR did not identify that the DOC was notified the day before the CIR was submitted, that RPN #133 had reported that RPN #132 was found reordering controlled substances for a resident that was not in their care and that resident #009 later confirmed that RPN #132 had signed as administering a non-narcotic analgesic in place of their prescribed narcotic.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 13th day of June, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111)
Inspection No. / No de l'inspection :	2019_643111_0008
Log No. / No de registre :	002477-18, 009513-18, 026347-18, 002331-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 31, 2019
Licensee / Titulaire de permis :	Glen Hill Terrace Christian Homes Inc. 200 Glen Hill Drive South, WHITBY, ON, L1N-9W2
LTC Home / Foyer de SLD :	Glen Hill Strathaven 264 King Street East, Bowmanville, ON, L1C-1P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Stroud

To Glen Hill Terrace Christian Homes Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s.135(1).

Specifically,

1. Retrain all registered nursing staff to ensure the following:

a. All medication incidents are documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

b. Ensure that medication incidents are reported to the resident, the resident's SDM, Director of Nursing, Medical Director or the prescriber of the drug (physician or registered nurse in the extended class), and the pharmacy service provider.

c. Keep a record of the training.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident was: (a) documented, together with a record of the immediate actions

taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, and the Medical Director.

A critical incident report was submitted to the Director on a specified date, for missing/unaccounted for narcotic and controlled substances. The CIR indicated on a specified date, RPN #133 discovered the narcotics for resident #005 had been tampered with by RPN #132 and the narcotics were unaccounted for. The CIR was amended on a later date to indicate resident #006, #007 and #008 also had missing/unaccounted for narcotic and/or controlled drugs.

Review of the licensee's policy on Medication Incident Report (9-1), revised April 2016, indicated that when a medication incident occurs, the registered staff are to record it on the medication incident report form and communicate it to proper authorities (e.g. DOC/ADOC/Physician/Pharmacy).

Review of the medication incident report form for resident #005, completed on a specified date, indicated RPN #133 discovered a specified number of a specified narcotic was missing and had been replaced with other medication. There was no evidence the Substitute Decision Maker (SDM) or the Medical Director (MD) were notified. The incident report was completed by the DOC.

Review of the progress notes for resident #005 during a specified period, indicated there was no documented evidence to indicate the immediate actions taken to assess and maintain the resident's health or to indicate the resident's SDM or the MD were notified.

During an interview with RPN #133 by Inspector #111, the RPN indicated on a specified date, they arrived for work at a specified time, to relieve RPN #132. RPN #133 indicated they witnessed RPN #132 at the medication cart, taping the back of one of the residents narcotic cards. RPN #133 indicated they then completed a narcotic shift count with RPN #132 and the count appeared correct. RPN #133 indicated when they checked the cards again, they noted the card with the tape on the back had a number of the narcotics replaced with different medication and immediately reported this to the DOC. The RPN confirmed they did not complete a medication incident report for this incident and could not recall if the SDM or the Medical Director were notified.

During an interview with the DOC by Inspector #111, they indicated the expectation was that any nurse who discovered a medication incident, including missing narcotic/controlled substances, was to complete the medication incident report form, notify the DOC, Physician, SDM and the Medical Director. The DOC confirmed a medication incident report was completed for resident #005 by the DOC after the RPN reported the incident to them. The DOC also confirmed the SDM and the Medical Director were not informed of the medication incident.

Review of the home's investigation and review of the health records of resident #006, #007, #008 and #00 for the large quantity of missing/unaccounted for narcotics and/or controlled substances indicated the following:
-Resident #006: review of the Medication Administration Records (MAR) and the Narcotic/Controlled substances records indicated there was multiple entries with inaccurate documentation of narcotics/controlled substances and borrowing the resident's narcotics for other residents completed by RPN #132.
-Resident #007: review of MAR and the Narcotic/Controlled substances records indicate there was inaccurate documentation completed, there was a large quantity of narcotics/controlled substances administered during a specified period of time and there were multiple dates when RPN #132 was borrowing the resident's controlled substance, for other residents.
-Resident #008: had reported that RPN #132 had attempted to administer a non-narcotic analgesic instead of their prescribed narcotic which was witnessed by a family member.
-Resident #009: on a specified date, RPN #133 discovered that RPN #132 had documented on the narcotic record that they administered a few narcotics to the resident on a specified date and time, but there was no documentation in the MAR or in the resident's progress notes. The RPN confirmed with the resident that they had not received the drug and reported the incident to the DOC. Review of the progress notes for resident #009 confirmed the resident had been in pain. There was no evidence the resident's SDM or the MD were notified.
-There were no medication incident reports completed for resident #006, #007, #008 and #009, who had missing/unaccounted narcotics and/or controlled substances.

During an interview with RPN #133 by Inspector #111, the RPN confirmed they had discovered that on a specified date and time, RPN #132 had documented on the individual narcotic drug record sheet for resident #009, that they had

administered narcotics to the resident but the resident denied ever receiving them and had been in pain. RPN #133 was unable to recall if a medication incident report was completed for this incident, or if they notified the resident's SDM or the MD. RPN #133 confirmed they reported the medication incident to the DOC, but was unable to recall when they notified the DOC.

During an interview with the DOC, the DOC indicated there was no medication incident reports completed for the missing/unaccounted controlled substances for resident #006, #007, #008 and #009. The DOC was unable to indicate when those medication incidents were discovered, but indicated they were discovered between a specified period of time, during the investigation. The DOC confirmed that the SDM's for resident's #006, #007 and #009 were not informed of the medication incidents. The DOC confirmed RPN #132 was also improperly documenting the administration of narcotics and controlled substances. The DOC indicated they determined that RPN #132 had signed as administering a large quantity of narcotics to resident #006, over a specified period but were unable to verify if the resident received them due to cognitive impairment. The DOC confirmed it was against the home's policy to borrow narcotics/controlled substances for other residents. The DOC indicated RPN #132 had signed as administering a large quantity of narcotics and controlled substances to resident #007, over a specified period and resident #007 denied receiving them. The DOC indicated resident #008 had reported to the DOC on a specified date, that when they had requested their narcotic for pain, RPN#132 had attempted to give them a non-narcotic analgesic instead. The DOC indicated that RPN #133 had also reported that on a specified date, they had discovered RPN #132 had documented on resident #009's narcotic sheet a few day before, at a specified time, that they had administered a number of narcotics to the resident but the resident continued to have pain and had to be administered another dose a short time later by another RPN. The DOC indicated that RPN #133 confirmed with resident #009 that they had never received their narcotic from RPN #132 on the specified date and was in pain. The DOC confirmed there was no medication incident report completed for this medication incident that wasn't reported until a few days later. The DOC confirmed the Medical Director was not informed of any of the medication incidents involving resident #006, #007, #008 and #009. The DOC confirmed there were no documented evidence to indicate the residents were assessed or actions taken, for resident #006, #007 and #009, after the medication incidents were discovered.

The licensee has failed to ensure that every medication incident involving a resident was documented, as there were no medication incident reports completed for the medication incidents involving resident #006, #007, #008 and #009. The medication incidents involving resident #005 and #009 did not include a record of the immediate actions taken to assess and maintain the resident's health. The medication incidents involving resident #006, #007 and #009 were not reported to the resident's SDMs and the MD was not informed of the medication incidents, involving resident #006, #007, #008 and #009.

2. The licensee has failed to ensure that (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

There were two separate critical incident reports submitted to the Director on two specified dates for missing/unaccounted narcotics and controlled substances . The first CIR indicated on a specified date, RPN #115 had discovered that RPN #132 had reordered and received a large number of narcotic and/or controlled substances for two different residents (resident #003 and #004), the drugs were unaccounted for and the police were notified.The Second CIR indicated RPN #132 no longer worked in the home.

Review of the health record for resident #003 indicated the resident had a diagnoses that caused a specified responsive behaviour and was prescribed an as needed (PRN) controlled drug.

Review of the health record for resident #004 indicated the resident had pain related diagnoses and was prescribed a PRN narcotic analgesic.

Review of the health care record for resident #005 indicated the resident had pain related diagnoses, had ongoing pain to specified areas and was prescribed a PRN narcotic analgesic.

Review of the health record for resident #006 indicated the resident had pain related and responsive behaviour related diagnoses. The resident was prescribed a PRN narcotic and PRN controlled drug.

Review of the health record for resident #007 indicated the resident was admitted with multiple pain related diagnoses and was prescribed both routine and PRN narcotic analgesics. The resident was also prescribed a PRN controlled drug for a responsive behaviour related diagnosis.

Review of the Narcotic Counts & Surplus Discontinued Narcotic and Controlled Medications policy (VI-J-10.46), revised on March 2018, indicated the RN/RPNs will: report any discrepancies over numbers of controlled substances/narcotics/PRN anxiolytics between shifts to the Director of Care immediately.The Director of Care will Investigate and respond to all discrepancies.

Review of the Ordering Narcotic and Controlled Medications policy (6-2) (reviewed September 2016), under Re-Orders, facility staff may re-order as per re-order procedure.

A review of the home's investigation by Inspector #111, indicated in addition to the missing/unaccounted narcotic and controlled substances involving RPN #132, there were also incidents when RPN #132 was noted to be excessively administering PRN narcotics/controlled substances or signing for narcotics, but not administering them to the residents.

During an interview with the DOC by Inspector #111, the DOC confirmed that RPN #132 had been reordering and receiving a large quantity of narcotics and controlled substances for resident #003 and #004 who were not in their care, and RPN #132 could not indicate why the narcotic/controlled substances were unaccounted for or included in the shift count when they were received by the RPN. The DOC confirmed no further investigation or corrective actions were taken with RPN #132 after the first critical incident. The DOC indicated after the second critical incident, they again discovered that RPN #132 had been reordering narcotics and controlled substances for residents not in their care, RPN #132 continued to work and no investigation was completed until the following day. The DOC confirmed RPN #132 was not relieved of duty until the following day, when the RPN was found unfit to work. The DOC indicated after RPN #132 had left the home, they discovered that RPN #132 had tampered with narcotics that belonged to resident #005 and notified the police. The DOC

indicated at that time, as part of their investigation, they complete an audit of all the narcotic/controlled substances and noted several dates where RPN #132 was reordering and receiving narcotic/controlled drugs and discovered there was a large quantity of missing/unaccounted for narcotics and controlled substances. The DOC indicated they also noted that RPN #132 had been documenting that they had been excessively administering narcotic and/or controlled substances to residents #006, #007 and #008 during a specified period on the unit they worked on. The DOC indicated as a result of the investigation, they confirmed a large quantity of narcotic and controlled substances were missing/unaccounted for, all involving RPN #132. The DOC indicated the licensee's reorder policy was updated to include that the registered nursing staff should only be reordering narcotics and controlled substances for residents that they are assigned to provide care.

During an interview with the Administrator, they confirmed RPN #132 no longer worked in the home as a result of the investigation into the missing/unaccounted for narcotic/controlled substance, after the second CIR was submitted. The Administrator confirmed the police and College of Nurses were also notified. The Administrator indicated RPN #132 was found reordering PRN narcotic and controlled substances for residents that were not in their care, receiving the narcotic/controlled substances but not including them in the narcotic shift count and documenting excessively administering PRN narcotic/ controlled substances to residents. The Administrator indicated they noted that the incidents of reordering/receiving of narcotics/controlled substances only occurred when RPN #132 was working a specified. The Administrator indicated during a later interview, that RPN #141 had confirmed awareness of RPN #132 excessively administering narcotics and controlled substances to residents on their unit, but did not report it.

There were eight residents (resident #003, #004, #005, #006, #007, #008, #009 and #010) involved in a large quantity of missing/unaccounted controlled substances, all involving RPN #132, over a specified period. The licensee failed to take corrective actions on a specified date, when narcotic/controlled substances were missing/unaccounted for. In addition, the home failed to review and analyze a medication incident on a specified date, when the same RPN was involved, until the following day, after the RPN was found unfit to work. RPN #132 was allowed to continue to work, allowing further access to the

narcotic/controlled substances on a specified date, where additional narcotic/controlled substances went missing. The RPN was then returned to work the following day, completed two narcotic shift counts, allowing additional access to the narcotic/controlled substances, and more narcotic/controlled substances were unaccounted for.

The scope was a level 3, widespread as there were multiple residents involved and on more than one unit. The severity was a level 3, actual harm, actual risk, as there were residents who may not have received their medications as prescribed; residents who did not receive their medications as prescribed and had pain and who were offered the wrong medication and resulted in pain. The compliance history was a level 3, as previous non-compliance issued for the same area, as follows:
-issued a Voluntary Plan of Correction (VPC) on June 20, 2018 during inspection # 2018_578672_0004. (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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 no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;
(b) corrective action is taken as necessary; and
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Order / Ordre :

The licensee shall comply with O.Reg. 79/10, s.135(2)

Specifically,

1. Develop and implement, a system or process to ensure that all medication incidents are documented, reviewed and analyzed, including misappropriation of narcotics and controlled substances.

2. Develop and implement a system or process to ensure corrective action is taken immediately, when a medication incident is discovered or reported, specifically with misappropriation of narcotics and controlled substances.

3. The DOC or designate, shall ensure a written record is kept of these medication incidents, including the review and analysis of these medication incidents, and of the corrective actions that were taken to address these medication incidents.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident was: (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and (b) reported to the resident, the resident's SDM, if any, and the Medical Director.

A critical incident report was submitted to the Director on a specified date, for missing/unaccounted for narcotic and controlled substances. The CIR indicated on a specified date, RPN #133 discovered the narcotics for resident #005 had been tampered with by RPN #132 and the narcotics were unaccounted for. The CIR was amended on a later date to indicate resident #006, #007 and #008 also had missing/unaccounted for narcotic and/or controlled drugs.

Review of the licensee's policy on Medication Incident Report (9-1), revised April 2016, indicated that when a medication incident occurs, the registered staff are to record it on the medication incident report form and communicate it to proper authorities (e.g. DOC/ADOC/Physician/Pharmacy).

Review of the medication incident report form for resident #005, completed on a specified date, indicated RPN #133 discovered a specified number of a specified narcotic was missing and had been replaced with other medication. There was no evidence the Substitute Decision Maker (SDM) or the Medical Director (MD) were notified. The incident report was completed by the DOC.

Review of the progress notes for resident #005 during a specified period, indicated there was no documented evidence to indicate the immediate actions taken to assess and maintain the resident's health or to indicate the resident's SDM or the MD were notified.

During an interview with RPN #133 by Inspector #111, the RPN indicated on a specified date, they arrived for work at a specified time, to relieve RPN #132. RPN #133 indicated they witnessed RPN #132 at the medication cart, taping the back of one of the residents narcotic cards. RPN #133 indicated they then completed a narcotic shift count with RPN #132 and the count appeared correct. RPN #133 indicated when they checked the cards again, they noted the card with the tape on the back had a number of the narcotics replaced with different medication and immediately reported this to the DOC. The RPN confirmed they did not complete a medication incident report for this incident and could not recall if the SDM or the Medical Director were notified.

During an interview with the DOC by Inspector #111, they indicated the expectation was that any nurse who discovered a medication incident, including

missing narcotic/controlled substances, was to complete the medication incident report form, notify the DOC, Physician, SDM and the Medical Director. The DOC confirmed a medication incident report was completed for resident #005 by the DOC after the RPN reported the incident to them. The DOC also confirmed the SDM and the Medical Director were not informed of the medication incident.

Review of the home's investigation and review of the health records of resident #006, #007, #008 and #00 for the large quantity of missing/unaccounted for narcotics and/or controlled substances indicated the following:
-Resident #006: review of the Medication Administration Records (MAR) and the Narcotic/Controlled substances records indicated there was multiple entries with inaccurate documentation of narcotics/controlled substances and borrowing the resident's narcotics for other residents completed by RPN #132.
-Resident #007: review of MAR and the Narcotic/Controlled substances records indicate there was inaccurate documentation completed, there was a large quantity of narcotics/controlled substances administered during a specified period of time and there were multiple dates when RPN #132 was borrowing the resident's controlled substance, for other residents.
-Resident #008: had reported that RPN #132 had attempted to administer a non-narcotic analgesic instead of their prescribed narcotic which was witnessed by a family member.
-Resident #009: on a specified date, RPN #133 discovered that RPN #132 had documented on the narcotic record that they administered a few narcotics to the resident on a specified date and time, but there was no documentation in the MAR or in the resident's progress notes. The RPN confirmed with the resident that they had not received the drug and reported the incident to the DOC. Review of the progress notes for resident #009 confirmed the resident had been in pain. There was no evidence the resident's SDM or the MD were notified.
-There were no medication incident reports completed for resident #006, #007, #008 and #009, who had missing/unaccounted narcotics and/or controlled substances.

During an interview with RPN #133 by Inspector #111, the RPN confirmed they had discovered that on a specified date and time, RPN #132 had documented on the individual narcotic drug record sheet for resident #009, that they had administered narcotics to the resident but the resident denied ever receiving them and had been in pain. RPN #133 was unable to recall if a medication

incident report was completed for this incident, or if they notified the resident's SDM or the MD. RPN #133 confirmed they reported the medication incident to the DOC, but was unable to recall when they notified the DOC.

During an interview with the DOC, the DOC indicated there was no medication incident reports completed for the missing/unaccounted controlled substances for resident #006, #007, #008 and #009. The DOC was unable to indicate when those medication incidents were discovered, but indicated they were discovered between a specified period of time, during the investigation. The DOC confirmed that the SDM's for resident's #006, #007 and #009 were not informed of the medication incidents. The DOC confirmed RPN #132 was also improperly documenting the administration of narcotics and controlled substances. The DOC indicated they determined that RPN #132 had signed as administering a large quantity of narcotics to resident #006, over a specified period but were unable to verify if the resident received them due to cognitive impairment. The DOC confirmed it was against the home's policy to borrow narcotics/controlled substances for other residents. The DOC indicated RPN #132 had signed as administering a large quantity of narcotics and controlled substances to resident #007, over a specified period and resident #007 denied receiving them. The DOC indicated resident #008 had reported to the DOC on a specified date, that when they had requested their narcotic for pain, RPN#132 had attempted to give them a non-narcotic analgesic instead. The DOC indicated that RPN #133 had also reported that on a specified date, they had discovered RPN #132 had documented on resident #009's narcotic sheet a few day before, at a specified time, that they had administered a number of narcotics to the resident but the resident continued to have pain and had to be administered another dose a short time later by another RPN. The DOC indicated that RPN #133 confirmed with resident #009 that they had never received their narcotic from RPN #132 on the specified date and was in pain. The DOC confirmed there was no medication incident report completed for this medication incident that wasn't reported until a few days later. The DOC confirmed the Medical Director was not informed of any of the medication incidents involving resident #006, #007, #008 and #009. The DOC confirmed there were no documented evidence to indicate the residents were assessed or actions taken, for resident #006, #007 and #009, after the medication incidents were discovered.

The licensee has failed to ensure that every medication incident involving a

resident was documented, as there were no medication incident reports completed for the medication incidents involving resident #006, #007, #008 and #009. The medication incidents involving resident #005 and #009 did not include a record of the immediate actions taken to assess and maintain the resident's health. The medication incidents involving resident #006, #007 and #009 were not reported to the resident's SDMs and the MD was not informed of the medication incidents, involving resident #006, #007, #008 and #009

The scope was a level 3, widespread as the medication incidents involved multiple residents on three different units. The severity was a level 3, actual harm, actual risk as some of the residents may not have received their prescribed narcotic analgesics for pain or controlled substances for anxiety as required. The compliance history was a level 3, previous non-compliance identified in a similar area as O.Reg. 79/10, s. 135 (1) was issued as follows: a Voluntary Plan of Correction (VPC) was issued on June 20, 2018 under inspection #2018_578672_0004. (111)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2019

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 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, 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:

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 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 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 de la Santé et 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 de la Santé et 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 May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Central East Service Area Office