Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 18, 2017	2017_508137_0022	023263-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

ELMWOOD PLACE
46 ELMWOOD PLACE WEST LONDON ON N6J 1J2

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

MARIAN MACDONALD (137), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 10-13 and 16-19, 2017

The following intakes were completed within the Resident Quality Inspection (RQI):

Log # 030429-16 / IL-47398-LO – complaint related to staffing.
Log # 016739-17 / IL-52022-LO – complaint related to care provision.
Log # 021440-17 / IL-52784-LO – complaint related to alleged neglect.
Log # 034093-16 / Critical Incident System (CIS) 2662-000010-16; Log # 004787-17 / CIS 2662-000004-17;
Log # 034092-16 / CIS 2662-000009-16 and Log # 012821-17 / 2662-000009-17 – related to missing or unaccounted for controlled substances.
Log # 017308-17 / CIS 2662-000010-17 -related to alleged neglect.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Associate Director of Care, Environmental Services Manager, Regional Director, Regional Manager, Consultant Pharmacist, Ward Clerk/Office Manager, Food Service Manager, two Registered Nurses, nine Registered Practical Nurses, five Personal Support Workers, two Housekeepers, residents, family members, representatives from Family and Residents' Councils.

The inspectors also toured the home, observed care provision, resident to staff interactions, medication administration, medication storage areas, reviewed residents' clinical records, relevant meeting minutes, internal investigative notes, medication incident reports, relevant policies and procedures, general maintenance and cleanliness of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Residents' Council
Sufficient Staffing

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

- **14 WN(s)**
- **9 VPC(s)**
- **5 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 LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was at least one registered nurse who was

an employee of the licensee and a member of the regular nursing staff on duty and present at all times, unless there was an allowable exception to this requirement.

An anonymous Info-line (IL-47398-LO and Log # 030429-16) complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to no Registered Nurse (RN) on duty in the home during an identified night shift.

MOHLTC Central Intake Assessment Triage Team (CIATT) conducted an inquiry and the Director of Care (DOC) stated there was a RN present for the 1900-0700 hours shift on the identified date but not between 1500-1900 hours on that day.

DOC also stated they would further recruit additional RN's, consult the regular RN's for "off-site (on-call) availability" for future unforeseeable events and that they were not aware that RN's were to be on-site at all times.

A review of the home's Registered Nurse schedules, for an identified time period, showed there were 22 scheduled shifts where there was no RN on duty and present at all times, including 0700-1900 hours and 2300-0700 hours on the date identified in the complaint.

There was documented evidence, on the schedules, that the Director of Care was on call for four shifts and in the building for another shift, during the identified dates.

During an interview, the Ward Clerk reviewed the Registered Nurse schedules with the Inspector and said there was no Registered Nurse on duty, during the 22 identified dates. During an interview, the Executive Director (ED) said there was no RN on duty in the home from 2300-0700 hours on the identified date.

During an interview, the Inspector reviewed the CIATT information, with the Director of Care. The DOC was unable to recall the incident. The Inspector asked the DOC if there were any internal notes, related to the incident. The DOC provided a copy the internal notes and documented evidence that the identified 2300-0700 hours shift was replaced with a Registered Practical Nurse (RPN).

During the Resident Quality Inspection (RQI), observations showed there was no RN on duty and present in the home from 0700-1900 hours, on an identified date. The DOC was observed to be wearing a white lab coat and said they wore this when they were the RN in the building.

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

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 8. (3)]

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. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Inspector requested to review the annual evaluation of the medication management system in the home. During an interview, the Assistant Director of Care (ADOC) acknowledged that there was no documented evidence that the staff of the home met annually in 2016 or 2017 to evaluate the effectiveness of the medication management system and to recommend any changes necessary to improve the system.

The licensee failed to ensure that an interdisciplinary team met annually to evaluate the effectiveness of the medication management system.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread, and there was no history of previous related noncompliance. [s. 116. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured.

An observation showed a treatment cart left unattended in the hallway, outside a medication room. There was betadine and treatment supplies on top of the cart, which were accessible to two residents walking in the hallway and five residents seated in the adjacent dining room.

A Registered Nurse (RN) arrived and observed the unattended treatment cart. The RN said the cart was not to be left unattended, with treatment supplies on top that were accessible to residents, and the cart was to be kept in the medication room when not being used. [s. 129. (1) (a) (ii)]

2. The licensee has failed to ensure that controlled substances were 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) An Inspector observed the medication room on the second floor with a Registered Practical Nurse (RPN). The RPN unlocked the medication room by key access, opened the mini white refrigerator and removed a small black locked box with a key pad noted on the lid and placed it on the counter. The RPN unlocked the black box by key access and verified that the box contained five vials of an injectable controlled substance.

The RPN stated that the injectable controlled substance was kept locked in the medication room refrigerator and was counted at shift change. The RPN acknowledged that they were able to remove the black locked box containing the injectable controlled substance and that it was not stationary.

Review of the Medisystem Pharmacy Drug Inventory Control policy last reviewed January 16, 2017, stated narcotics and control substances must be stored in a double locked container in the medication cart or in the medication room. Medications in the medication room were to be stored in a secured, locked location, accessible only to designated staff members.

Review of the Medisystem Medication System policy last review January 17, 2017 stated refrigerated narcotic and controlled substances must be double locked in the refrigerator.

The Consultant Pharmacist (CP) was asked to read parts of the Medisystem Pharmacy Drug Inventory Control policy and the Medisystem Medication System policy related to controlled substances storage. The Inspector asked if the refrigerated locked black emergency box holding the injectable controlled substance was stored in a separate, double-locked stationary location in the locked medication room. The CP acknowledged that the policies did not speak to the 'stationary' aspect of narcotic storage and shared that there was a black locked box in the refrigerator that could be easily removed and was not stationary.

The Director of Care (DOC) acknowledged that the black storage box in the medication refrigerator was not stationary and a staff member could remove the controlled substance storage area from the medication room.

B) An Inspector observed the medication cart with a RPN present. The Inspector opened the bottom drawer of the medication cart and pulled the lid open from the narcotic storage area without a key. The RPN observed this and verified that the narcotic storage area in the medication cart was unlocked. The RPN shared that the drawer should be locked at all times and that it was not shut hard enough.

C) Inspectors observed the first floor medication room where the storage area for narcotics for destruction was located. An Inspector was able to easily pick up and remove the narcotic storage area from the shelf under the counter. Observation of the storage area determined that there was no hardware noted that secured the storage area

to the shelf or wall. The RPN shared it was a new storage area when Medisystem Pharmacy took over and that Classic Care removed theirs and Medisystem supplied their own. The Executive Director and the Assistant Director of Care (ADOC) arrived immediately and verified that the narcotic storage area for controlled substances for destruction should be double locked and stationary.

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

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and compliance history a level three, as there was a history of previous related noncompliance. [s. 129. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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 was established, maintained and kept in the home for at least two years, in which was recorded the following information, in respect of every drug that was ordered and received in the home:
1. The date the drug was 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 was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was 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).

During the Resident Quality Inspection, four Critical Incidents were inspected related to missing controlled substances for an identified time period. The ordering and receipt of narcotics and controlled substances was reviewed.

The home's drug record was reviewed with a Registered Practical Nurse (RPN).

The RPN showed an Inspector a medication ordering form where pharmacy labels were applied or the order was handwritten by the nurse. The medications were then delivered with a packing list of medications received and the receiving nurse verified the medications and signed and dated the packing list form. The RPN acknowledged that there were receipts that were not signed and dated by registered staff and that there were also medications ordered where the handwritten orders did not contain the information required.

The ADOC shared that they were unsure of the drug record process for ordering and receiving medications, but that it appeared that some staff were signing and dating the order form and some were signing and dating the medication receipt "packing slip" from pharmacy. The ADOC acknowledged that there were receipts that were not signed and dated by registered staff for both non-controlled and controlled substances for multiple residents and that there were also medications ordered where the handwritten orders did not contain the information required. The ADOC also shared there was no order form

completed for four identified residents and the controlled substances received from pharmacy had no staff signature or date on the medication receipt "packing slip" from pharmacy.

Review of the Medisystem "Ordering and Receiving Medications" policy last reviewed January 17, 2017, stated the "Drug Record Book" was a legal document of all medications ordered and received by the home. As such the drug record book must include all new orders, reorders and medications ordered and received by pharmacy.

Review of the Medisystem "Medication Reorder Sheet" documented 13 medications reordered from pharmacy with the following information missing:
• The date the drug was ordered was missing on two entries
• The name, strength and quantity of the drug was missing on eight entries
• The prescription number was missing on eight entries
• The date the drug was received in the home was missing on all 13 entries for reordering
• The signature of the person acknowledging receipt of the drug on behalf of the home was missing on all 13 entries for reordering.

The ADOC acknowledged that there was missing information required when ordering and receiving medications from pharmacy on the Medication Reorder Sheet.

The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the appropriate information in respect of every drug that was ordered and received from pharmacy.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 133.]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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.

The home's medication incidents were reviewed for an identified time period.

A) A Medication Incident Report (MIR) was completed for an identified resident. The incident report did not identify the staff member who made the medication error. A controlled substance was not given to the resident and the type of error was documented as an omission. The incident report documented that the event was not communicated to the physician, the resident and/or Substitute Decision Maker (SDM), or the pharmacy service provider. There were no progress notes in PointClickCare (PCC) for the monitoring and assessment of the resident related to the omission of the controlled substance.
The Director of Care (DOC) shared that there was no documented evidence that the physician was made aware of the medication incident.

B) A Medication Incident Report was completed for a second identified resident. A medication was not removed as ordered and the incident was documented as an expired medication. The incident report documented that the event was not communicated to the pharmacy service provider. There were no progress notes or vital sign monitoring documented in PCC for the resident related to the expired medication.

C) A Medication Incident Report was completed for a third identified resident.The incident documented that medications were signed as given. The MIR documented that the physician was checked as notified, however for pharmacy it stated "online incident completed?" The Consultant Pharmacist shared pharmacy was not notified of the medication incident related to the identified resident. The DOC shared that when a paper hard copy of an incident was completed it should be faxed to pharmacy and then sent to the DOC.

D) A Medication Incident Report was completed for a fourth identified resident. The incident documented that the origin of the error was from pharmacy. The medication order was transcribed incorrectly in the electronic Medication Administration Record (eMAR) than what was documented on the blister pack. The Inspector asked why the medication order was not corrected in PCC at the time it was discovered as incorrect and the RPN acknowledged that it should have been changed and that the discrepancy created a nursing medication error twice on an identified date. There was no documentation of monitoring or assessment in PCC of the identified resident, related to this incident.

E) The home submitted two Critical Incident System (CIS) reports, 2662-000009-16 and 2662-000010-16, to the Ministry of Health and Long-Term Care (MOHLTC) related to missing controlled substances for two identified residents. The DOC verified that there was no MIR completed for both residents, related to missing controlled substances.

Record review of the Revera LTC- Medication Incidents policy last reviewed July 31, 2016 stated if the medication incident was resident related, the nurse would assess the residents' condition and take immediate action as required. The physician, substitute decision-maker/family would be informed of all resident related incidents and the nurse would determine whether the physician/substitute decision-maker required notification immediately, within the next 12 hours or at the next visit.

The DOC shared that a record of the immediate actions taken to assess and maintain the resident's health should be in the progress notes in PCC, but also in Risk Management for any adverse reactions and in the Medication Incident Report online. The expectation was that for all residents involved in a medication incident, that a progress note documented the monitoring and assessment.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health.

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything.

A Medication Incident Report was completed for an identified resident. The incident

documented that medications were signed as given.The MIR documented that the physician was checked as notified, however for pharmacy it stated "online incident completed?"

The DOC was asked for the name and designation of the staff involved and the DOC shared that they remembered talking to this person. The MIR follow up comments/corrective actions (DOC) documented "spoke to staff member who states the correct medication was given but not at the scheduled time. The DOC verified that there was corrective action taken and the registered staff member involved was spoken to but the RPN shared that they had never spoken to the DOC about this medication incident.

The licensee has failed to ensure that corrective action was taken as necessary related to the medication incident for an identified resident.

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything.

The Executive Director (ED) provided copies of the medication incident reports (MIRs) for the last reviewed quarter. The ED shared that the last reviewed quarter was January to March 2017 and the last Professional Advisory Committee (PAC) meeting was in April 2017. The ED shared that the home switched pharmacy providers in March 2017 from Classic Care Pharmacy to Medisystem. The ED also stated that the July PAC meeting was cancelled due to poor attendance, verifying that the April PAC meeting was the last time the home conducted a quarterly review of the medication incidents.

Review of the "Professional Advisory Committee with Multidisciplinary Team Meeting Minutes" dated April 30, 2017, stated the "roundtable updates" included review of medication incidents. The meeting minutes documented that the medication incidents were pharmacy generated, that errors of omissions were common and incidents where Medisystems was at fault was due to a changeover in systems.

An Inspector requested copies of all medication incident reports completed during a specified time period and the DOC provided a copy of three medication incidents reported and the medication incidents were nursing errors. There was no documentation provided that a pharmacy error occurred during this time.

The Consultant Pharmacist (CP) acknowledged that they were present during the quarterly review of medication incidents at the PAC meeting in April 2017. The CP also verified that there had not been another quarterly review since April. The Inspector shared that the DOC stated that there were three MIRs that occurred during a specified time period and the Inspector reviewed the dates and associated resident names. The CP shared that there were also four other medication incidents during that time period and that they were submitted to Medisystem online. The four medication incidents were related to pharmacy errors.

Review of the Medication Incident Reports during a specified time period included the following:
- A controlled substance was discarded before administration. The error was an omission by a Registered Nurse.
- A medication was not removed as ordered. The medication incident was a nursing error related to an expired medication.
- Controlled substances were missing for an identified resident.

Review of the Medisystem Medication Incidents policy last reviewed January 17, 2017, stated the medication incident reports would be analyzed by nursing administration, the pharmacy manager, and/or the consultant pharmacist to determine whether pharmacy and or nursing procedures required modification. The Pharmacy and Therapeutics Committee would also review a summary of all medication incidents at scheduled nursing home meetings to determine if corrective actions were necessary to prevent future harm.

Record review of the Revera LTC- Medication Incidents policy last reviewed July 31, 2016, stated:
"Medication incidents would be summarized, discussed and action plans developed as necessary (e.g. Professional Advisory Committee)".

The Executive Director acknowledged that a quarterly review was not undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in April 2017.

The Director of Care acknowledged that the quarterly review on April 30, 2017 of medication incidents during a specified time period did not include documentation related to the missing controlled substance and improper destruction of a controlled substance.

There was no documented evidence that a quarterly review was undertaken of all medication incidents and adverse drug reactions in the home since the time of the last review.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 135.]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when, the resident's care needs changed or care set out in the plan was no longer necessary.

A progress note in Point Click Care (PCC) documented the use of a fall prevention device as a safety measure for an identified resident due to high risk for falls, non-compliance with calling for assistance, cognitive impairment and generalized weakness. Review of the progress notes documented that the identified resident had sustained several falls during a specified time period.

A Housekeeper shared that some fall prevention devices were connected to the call bell system and some were not. They shared that the identified resident should have the fall

prevention device connected to the call bell system as the resident got out of bed on their own all the time and had a history of falls. A RPN shared the resident did have a fall prevention device in place previously.

The Assistant Director of Care (ADOC) and Executive Director (ED) stated that the use of the fall prevention device was monitored in Point of Care (POC) under safety and monitoring of falls equipment as per the care plan and was an intervention in the kardex for all residents who used such devices. The ADOC verified that the care plan would be updated to reflect interventions put in use when the resident's needs changed. Inspector asked how a registered staff member would decide whether to use the fall prevention device connected to the call bell system compared to those devices that were not connected to the call bell system. The ADOC verified that there was no documented criteria for the use of one system over another.

An Inspector asked the PSWs at which point in the hallway that the fall prevention device was audible and the PSWs replied by pointing to room next door. A PSW said the fall prevention device should be connected to the call bell system for them to hear it.

The PCC documentation in POC was reviewed for the question, "Falls safety devices/checks as per Care Plan" and the question was not answered by the PSW staff.

Review of the current care plan documented that a fall prevention device was recently created by the ADOC. The care plan was not updated when the use of the fall prevention device was put in place at a previously identified date. The care plan was updated after Inspectors reported that the resident was activating the fall prevention device with no staff response.

The licensee has failed to ensure that an identified resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to the use of a fall prevention device and whether the device should have been connected to the call bell system to ensure staff response.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level one, isolated and the compliance history was a level three, as there was a history of previous related noncompliance. [s. 6. (10) (b)]

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 the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Ontario Regulation 79/10, s.30(1)1. states: "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation there must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.

The Long-Term Care Home Act, s. 8(1)(a) states: "Every licensee of a long-term care

home shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents".

The Long-Term Care Home Act, 2007, s.8(3) states ”Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations”.
The Long-Term Care Home Act, 2007, s.8(4) states “During the hours that an Administrator or Director of Nursing and Personal Care works in that capacity, he or she shall not be considered to be a registered nurse on duty and present in the long-term care home for the purposes of subsection (3), except as provided for in the regulations”.

A review of the “Elmwood Place Staffing Plan” showed that the plan/strategy for replacing RN's on days, evenings and nights was “to call all available RN's, ask RN to stay later, ask RN to come in early, replace with RPN, replace with Agency or DOC or re-assignment of Registered Staff onsite to cover all units/RHA's”.

The home's staffing plan was not in compliance with and was not implemented in accordance with the applicable requirements under the Act, related to staffing and care standards, specifically where every licensee of the long-term care home shall ensure that the home met the staffing and care standards provided for in the regulations (LTCHA, 2007, S.O.2007,c.8, s.17). [s. 8. (1) (a)]

2. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

A) Ontario Regulation 79/10,s.136(1) states in part "That every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy was developed in the home that provided for the ongoing identification, destruction and disposal of a resident's drugs where the resident dies, subject to obtaining the written approval of the person who had signed the medical certificate of death under the Vital Statistics Act or the resident's attending physician".

During an observation of the medication cart with a Registered Practical Nurse (RPN), the Inspector saw that there was an unlabelled bottle of medications stored was in the top drawer of the medication cart. The RPN verified that the medication was for a deceased resident.

Review of the Medisystem Pharmacy Drug Inventory Control policy last reviewed January 16, 2017 stated medications would be identified, destroyed and disposed of that were no longer required due to being discontinued or when a resident was discharged or deceased.

Consultant Pharmacist (CP) verified that all medications should remain in the original labelled package from pharmacy, and medications were not to be provided by family. The CP also verified that where the resident was deceased or was discharged, the resident’s medication was to be destroyed and disposed of.

The licensee has failed to ensure that the home's pharmacy medication policy related to drug inventory control was complied with.

B) Ontario Regulation 79/10, s. 114 (2) states, "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."

During the Resident Quality Inspection, four Critical Incidents were inspected related to missing controlled substances during a specified time period. The daily count sheets of controlled substances were reviewed for this time period.

Record review of the Revera LTC - Narcotic and Controlled Drugs Management policy last reviewed July 31, 2016 stated in part, "Two Nurses, together upon opening the narcotic and controlled drug(s) sealed container/bag, must verify, inspect for damage, and document drug and amount received on a Narcotic and Controlled Drug Count Form." The policy also stated, "Two Nurses, one from outgoing shift and one from incoming shift, will count and sign off on the Narcotics and Controlled Drug Count Form every shift change."

The Assistant Director of Care (ADOC) acknowledged that there were 22 incidents where controlled substances were received from pharmacy with only one registered staff signature documented and 14 incidents where the Narcotic and Controlled Count Form, at shift change, was completed by only one registered staff member.

The ADOC and the Executive Director verified that there should be two staff signatures present for narcotics received from pharmacy and documented on the "Narcotic and

Controlled Drug Administration Record". The ADOC also verified that two nurses should complete the narcotic count at shift change and that the home's policy was not complied with.

C) Record review of the Revera LTC Narcotics and Controlled Drugs policy index CARE 13 – P20 last reviewed August 31, 2017, stated narcotics and controlled drugs would be administered, counted, documented, stored and removed from the home in accordance with Federal/Provincial requirements and professional practice standards.

The ADOC acknowledged that the professional practice standard for registered nursing staff was to sign the narcotic drug count sheet each time a narcotic or controlled substance was administered to a resident. The ADOC also verified that registered staff were to sign the narcotic administration record for all narcotics administered.

Review of the "Resident's Individual Narcotic and Controlled Drug Count Sheet" for an identified resident showed that the administration of the controlled substance was not signed for by the registered staff.

The licensee has failed to comply with the Revera LTC Narcotics and Controlled Drugs policy and the Narcotic and Controlled Drugs Management policy.

The severity of this area of non-compliance was determined to be a level one, potential for minimal risk, the scope was a level three, widespread and the compliance history was a level four, as there was a history of previous related noncompliance. [s. 8. (1) (b)]

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 any plan, policy, protocol, procedure, strategy or system is complied with and is implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

Inspectors observed the main floor dining room servery half door was open and unlocked with staff and residents circulating the main floor entrance and hallway.

The area was unsupervised as there were no staff inside or near the servery area. Also, the door from the servey leading to the hall and located across from the Executive Director's office was unlocked. There was food and fluids stored in the servery. Hazardous substances were observed on the bottom shelf of the steam table, located inside the servery.

The Regional Director verified that the dining room servery doors were to remain closed and locked when unattended and shared that the half door to the main floor servery should be a full door. The Regional Director acknowledged that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they were not being supervised by staff.

The licensee has failed to ensure that the servery doors were kept closed and locked when they were not being supervised by staff.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level one, isolated and there was no history of previous related noncompliance. [s. 9. (1) 2.]

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 all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Observations by an Inspector showed that the fall prevention device for one identified resident was activated but not connected to the call bell system and was barely audible unless outside the resident's room. The Inspector observed the fall prevention device for a second identified resident. The device was connected to the call bell system but was not plugged into the wall adapter and was lying on the floor disconnected. An Inspector observed other fall prevention devices in use and noted that a third identified resident had a fall prevention device that was connected to the call bell system, however it did not activate until the Inspector pushed connections together at the sensor and the call bell system.

A Personal Support Worker (PSW) verified they did not check that the fall prevention device was connected to the call bell system for an identified resident and that PSWs were to check for connection, make sure cords were not tangled and that the equipment worked.

The Assistant Director of Care (ADOC) and Executive Director stated that the PSWs were expected to ensure the fall prevention equipment was in place and working when used by the resident, and that PSWs received an on floor orientation with a mentor with an additional day of training which included the monitoring and maintenance of fall prevention equipment.

The LTC-Medical Devices and Equipment policy last reviewed July 31, 2016, stated "for the use of medical devices and equipment the home would provide regular equipment maintenance/checks as per the manufacturer’s requirements. Before use, all devices and or equipment will be checked".

The ADOC provided the manufacturer’s instructions for the use of one type of fall prevention devices, but not for the use of the other type used in the home. The first type instructs staff to check the connection, positioning, function, and that the equipment was in good repair.

The Inspector observed an identified resident stand up from bed with the assistance of a PSW and the fall prevention device did not activate. When compressed, the device did not alarm to the call bell system or maintain a steady ring to alert staff. The device indicated a one year use with no recorded in-use date documented on it.

ADOC verified that the fall prevention devices were not dated and therefore could not verify if they exceeded the one year use and acknowledged that procedures were not implemented to ensure that all fall prevention devices in the home were kept in good repair.

As part of the organized program of maintenance, the licensee failed to ensure that procedures were implemented to ensure that all fall prevention devices in the home were kept in good repair.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level two, pattern and there was no history of previous related noncompliance. [s. 90. (2) (b)]

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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were labelled properly and were kept inaccessible to residents at all times.

Inspectors observed the housekeeping cart parked unlocked and unattended. A housekeeper left the cart unattended to walk down the hall towards the servery to retrieve a glass of water for a resident. There were four residents who walked past or near the cart who had access to the hazardous substances. The housekeeper acknowledged that there were hazardous substances and a small tool kit in the cart that was not locked when unattended.

The following cleaning products were observed in the storage area at the side of the housekeeping cart:
• Virex II 256 One-Step Disinfectant with a caution to avoid contact with eyes and skin,
• TimeMist 187 grams with a danger symbol that indicated the product contains an eye irritant,
• Easy Scrub Blue Cleanser with a caution to avoid contact with eyes and skin,
• Crew Bathroom Cleaner & Scale Remover with a caution to avoid contact with eyes, skin and clothing and

The housekeeper shared that the housekeeping cart did not lock and had not locked for several months and that a request was verbalized to the vendor of the cart over a year ago to repair the lock but the vendor did not return to complete that task.

The Environmental Service Manager (ESM) shared that a request was never submitted for the repair of the housekeeping cart on second floor. The ESM shared that work order sheets were available in the nursing station for anyone to complete related to maintenance services. The work order sheets were checked daily and repairs were done as soon as possible. Once a repair or maintenance service had been completed, the white copy of the sheet would be removed and the yellow copy remained at the nursing station as a reference. The ESM also showed the Inspector that there was no maintenance completed by the vendor of the cart in 2017.

Review of the work order sheets found in the second floor nursing station verified that there were no requests documented for maintenance related to the housekeeping cart.

Inspectors observed the bath/shower room on first floor. Inspectors noted that the door was wide open and the following chemicals were accessible to residents:
• Accel Intervention One Step Surface Cleaner may be harmful if swallowed, and could cause mild skin and eye irritation and
• Arjo All-Purpose Disinfectant Cleaner with a caution to avoid contact with eyes and skin.

Inspectors observed the main floor dining room servery. Inspectors noted the servery half door was open and unlocked with staff and residents circulating the main floor entrance and hallway and the servery door leading to the hall and located across from the Executive Director’s office was unlocked. The following chemicals were within reach and in plain sight on the bottom shelf near the half door:
• "D10 Concentrated Detergent/Disinfectant Diluted" with a caution label stating that it may cause eye and skin irritation and
• Virex II 256 One-Step Disinfectant Cleaner & Deodorant with a caution to avoid contact with eyes and skin.
Dietary Manager arrived and stated the chemicals were locked under the sink and an Inspector shared that there were chemicals under the steam table near the half door accessible to residents.

Inspectors observed the second floor dining room servery. Inspectors noted that upon approach the servery door was noted to be locked, however the key was hanging down

the wall on a blue plastic spiral cord near the locked door. One bottle of D10 Concentrated Detergent that could cause eye and skin irritation was accessible to residents.

On a second occasion, Inspectors observed the bath/shower room on first floor. The door to the room was wide open and the unlocked cupboard contained eight bottles of Biological Odor Eliminator accessible to residents. The Environmental Service Manager (ESM) stated a lock was to be added to the cupboard door, but recognized that there were chemicals accessible to residents and the door should be closed when unattended. A Personal Support Worker (PSW) walked past the tub room and stated that the door was always open and a Registered Practical Nurse (RPN) did not understand that the door was to be kept closed and locked when the tub room was not in use, as chemicals were accessible to residents.

The Regional Director verified that the ESM should be checking the housekeeping carts regularly to ensure proper function of the locking mechanism. The Regional Director also verified that all hazardous substances at the home were to be kept inaccessible to residents at all times.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 91.]

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 all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #11: 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. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

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:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of a missing or unaccounted for controlled substance.

The Critical Incident System (CIS) Report #2662-000009-17 documented that a controlled substance was discovered missing from a resident when the Registered Practical Nurse (RPN) went to administer another medication.

The Director of Care checked the calendar and verified that the incident should have been reported to the Ministry of Health sooner than it was reported and could not answer why it was late.

The licensee has failed to ensure that the Director was informed of the missing or unaccounted for controlled substance no later than one business day. [s. 107. (3) 3.]

2. The licensee has failed to make a report in writing to the Director setting out a description of the individuals involved in the incident, including names of any residents involved in the incident, and names of any staff members or other persons who were

present at or discovered the incident.

A Critical Incident System (CIS) Report #2662-000009-16 was submitted to the Ministry of Health and Long-Term Care (MOHLTC). The CIS documented a registered staff member went to remove controlled substances from two residents and discovered that the medications were missing. The CIS listed the name of the resident involved, however the name of the staff member present was absent from the report.

A CIS Report #2662-000009-17 was submitted to the MOHLTC. The CIS documented a controlled substance was discovered missing when the Registered Practical Nurse (RPN) was to administer another medication. The CIS listed the staff member who was present, however the name of the resident involved in the incident was absent from the report.

The Director of Care identified the resident involved. The "shift by shift witness form" for controlled substance checks was missing registered staff signatures on three separate occasions. The DOC acknowledged as part of the investigation there was no follow up with the registered staff involved in this medication incident during the 24 hours where the controlled substance was not monitored.

A CIS Report #2662-000004-17 was submitted to the MOHLTC. The CIS documented that “RPN noticed that the blister-card containing the resident's controlled substance for the afternoon was missing two pills.” The CIS listed the staff member who was present, however the name of the resident involved in the incident was absent from the report.

A CIS Report #2662-000010-16 was submitted to the Ministry of Health and Long-Term Care (MOHLTC. The CIS documented the resident's controlled substance was missing. The CIS listed the name of the resident involved, however the name of the staff member present was absent from the report.

The Director of Care acknowledged that the names of the residents involved in CIS #2662-000009-17 and #2662-000004-17 were absent. The DOC also verified that the staff members or other persons who were present at or discovered incident #2662-000009-16 and #2662-000010-16 were absent from the CIS.

The licensee has failed to make a report in writing to the Director setting out a description including names of any residents involved in the incident, and names of any staff members who were present at or discovered the incident.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level two, pattern and there was no history of previous related noncompliance. [s. 107. (4) 2.]

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 the Director is informed of the following incident in the home no later than one business day after the occurrence of a missing or unaccounted for controlled substance, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

Observations of the the medication cart by an Inspector, with a Registered Practical Nurse (RPN) present, showed that five packages of identified medications were in the medication compartment dedicated to an identified resident but were outside of the original labelled container provided by the pharmacy. Also, five unlabelled full and partial blister packages were noted stored in the top drawer of the medication cart. The RPN shared that the medication was from the government stock. Three boxes of other identified medications were also observed in the medication cart unlabelled and were provided by Public Health. The RPN acknowledged that the medications were not labelled for an identified resident.

An observation of the medication cart, with a Registered Practical Nurse (RPN) present, showed that one bottle of an identified medication was unlabelled, stored in the top drawer of the medication cart and the RPN verified that the medication was for an identified deceased resident.

The RPN acknowledged that the medications for an identified resident were not stored in their original labelled container provided by pharmacy.

Record review of the Revera LTC - Medication Administration policy last reviewed July 31, 2016, stated medications must remain in the original labelled containers or package provided by the pharmacy service provider or the government supply until administered to a resident.

The Consultant Pharmacist shared that all medications should remain in the original labelled package from pharmacy, and medications were not to be provided by family and only provided by pharmacy and for those treatments and medications provided by Public Health should be properly labelled by Public Health with resident identification.

The Director of Care (DOC) acknowledged that all drugs were to remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

An Inspector observed a second the medication cart with a RPN present. Five packages of identified medications were in the medication compartment dedicated to an identified resident and were outside of the original labelled container provided by the pharmacy. An injection device was noted in the top drawer of the medication cart with a home printed label with the name of an identified resident. The RPN acknowledged that the injection device was not labelled by pharmacy and shared that the label was applied when the resident's name was wearing off the original label.

The licensee has failed to ensure that identified medications remained in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level two, pattern and there was no history of previous related noncompliance. [s. 126.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #13: 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 steps were taken to ensure the security of the drug supply, including a monthly audit undertaken of the daily count sheets of controlled substances to determine if there were any discrepancies and that immediate action was taken if any discrepancies were discovered.

During the Resident Quality Inspection, four Critical Incidents were inspected related to missing controlled substances during a specific time period. The daily count sheets of controlled substances were reviewed for this time period.

The "Monthly Narcotic Audit of Count Sheets" for 2017 documented that Registered Nurse (RN)/Registered Practical Nurse (RPN) signature #1 and #2 were present with no discrepancies for monthly audits completed during a specific time period.

The Assistant Director of Care (ADOC) shared that there was no other documented evidence that a monthly audit of the daily count sheets of controlled substances was completed after May 2017. The ADOC also verified that the audit did not match the documentation as part of the "Narcotic and Controlled Drug Administration Record" where there were multiple missing signatures on an identified resident's "Resident's Individual Narcotic and Controlled Drug Count Sheet" and the "Elmwood Nursing Home Narcotic Ward Count”. The discrepancies were present, but not documented as part of the audits and there was no immediate action taken.

The licensee has failed to complete a monthly audit of the daily count sheets of controlled substances from June to September 2017. There were no immediate actions taken for identified discrepancies during a specific time period.

The severity of this area of non-compliance was determined to be a level one, minimal risk, the scope was a level two, pattern and there was no history of previous related noncompliance. [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 a monthly audit 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 #14: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The mandatory Medication Inspection Protocol (IP) was completed as part of the Resident Quality Inspection and medication incidents were reviewed during a specific time period. A Medication Incident Report (MIR) was completed for two identified residents, related to missing controlled substances. Review of the documentation showed both residents had an order for a controlled substance that was not administered as ordered by the physician.

A) A Registered Practical Nurse (RPN) and an Inspector reviewed a medication incident involving an identified resident, related to not receiving the prescribed dose of a controlled substance. The medication order was not entered into the electronic Medication Administration Record (eMAR) correctly and the registered nursing staff would just remind each other at shift change that the order in Point Click Care (PCC) was wrong and what the correct dose was to be administered.

The Inspector reviewed the "Physician's Orders History Report" and the "Narcotic and Controlled Drug Record" for the identified resident, with the Assistant Director of Care (ADOC). The ADOC acknowledged that the order for the controlled substance was inputted into the eMAR incorrectly and that on three occasions medication was not administered to the resident as prescribed.

B) The Inspector reviewed the “Physician's Order Form” for an identified resident, with the ADOC. The ADOC acknowledged that the order was for the administration of a controlled substance before an identified procedure.
Review of the eMAR showed that, on a specified date, the resident was administered two doses of the controlled substance instead of the one prescribed dose.

The licensee has failed to ensure that the controlled substances were administered to the identified residents in accordance with the directions for use specified by the prescriber.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level two, isolated and there was no history of previous related noncompliance. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 5th day of January, 2018

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

Ministére 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) :	MARIAN MACDONALD (137), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2017_508137_0022
Log No. / No de registre :	023263-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 18, 2017
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	ELMWOOD PLACE 46 ELMWOOD PLACE WEST, LONDON, ON, N6J-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Maynard

To REVERA LONG TERM CARE INC., 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must take action to achieve compliance with LTCHA, 2007, S.O. 2007, c.8, s.8(3) to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times.

Grounds / Motifs :

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

An anonymous Info-line (IL-47398-LO and Log # 030429-16) complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC), related to no Registered Nurse (RN) on duty in the home during an identified night shift.

MOHLTC Central Intake Assessment Triage Team (CIATT) conducted an inquiry and the Director of Care (DOC) stated there was a RN present for the 1900-0700 hours shift on the identified date but not between 1500-1900 hours on that day.

DOC also stated they would further recruit additional RN's, consult the regular RN's for "off-site (on-call) availability" for future unforeseeable events and that they were not aware that RN's were to be on-site at all times.

A review of the home's Registered Nurse schedules, for an identified time

period, showed there were 22 scheduled shifts where there was no RN on duty and present at all times, including 0700-1900 hours and 2300-0700 hours on the date identified in the complaint.

There was documented evidence, on the schedules, that the Director of Care was on call for four shifts and in the building for another shift, during the identified dates.

During an interview, the Ward Clerk reviewed the Registered Nurse schedules with the Inspector and said there was no Registered Nurse on duty, during the 22 identified dates.

During an interview, the Executive Director (ED) said there was no RN on duty in the home from 2300-0700 hours on the identified date.

During an interview, the Inspector reviewed the CIATT information, with the Director of Care. The DOC was unable to recall the incident. The Inspector asked the DOC if there were any internal notes, related to the incident. The DOC provided a copy of the internal notes and documented evidence that the identified 2300-0700 hours shift was replaced with a Registered Practical Nurse (RPN).

During the Resident Quality Inspection (RQI), observations showed there was no RN on duty and present in the home from 0700-1900 hours, on an identified date. The DOC was observed to be wearing a white lab coat and said they wore this when they were the RN in the building.

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

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 8. (3)] (137)

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

Ministére 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 2017

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. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Order / Ordre :

The licensee must take action to achieve compliance with O. Reg.79/10, s.116 (1) to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Grounds / Motifs :

1. The licensee has failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The Inspector requested to review the annual evaluation of the medication management system in the home. During an interview, the Assistant Director of Care (ADOC) acknowledged that there was no documented evidence that the staff of the home met annually in 2016 or 2017 to evaluate the effectiveness of the medication management system and to recommend any changes necessary to improve the system.

The licensee failed to ensure that an interdisciplinary team met annually to evaluate the effectiveness of the medication management system.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread, and there was no history of previous related noncompliance. [s. 116. (1)]
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(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).

Order / Ordre :

The licensee must take action to achieve compliance with:
O. Reg. 79/10, s.129(1)(a)(ii) to ensure that drugs are stored in an area or a medication cart that is secured and locked; and
O. Reg. 79/10, s.129(1)(b) 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.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured.

An observation showed a treatment cart left unattended in the hallway, outside a medication room. There was betadine and treatment supplies on top of the cart, which were accessible to two residents walking in the hallway and five residents seated in the adjacent dining room.

A Registered Nurse (RN) arrived and observed the unattended treatment cart.

The RN said the cart was not to be left unattended, with treatment supplies on top that were accessible to residents, and the cart was to be kept in the medication room when not being used. [s. 129. (1) (a)(ii)] (137)

2. The licensee has failed to ensure that controlled substances were 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) An Inspector observed the medication room on the second floor with a Registered Practical Nurse (RPN). The RPN unlocked the medication room by key access, opened the mini white refrigerator and removed a small black locked box with a key pad noted on the lid and placed it on the counter. The RPN unlocked the black box by key access and verified that the box contained five vials of an injectable controlled substance.

The RPN stated that the injectable controlled substance was kept locked in the medication room refrigerator and was counted at shift change. The RPN acknowledged that they were able to remove the black locked box containing the injectable controlled substance and that it was not stationary.

Review of the Medisystem Pharmacy Drug Inventory Control policy last reviewed January 16, 2017, stated narcotics and control substances must be stored in a double locked container in the medication cart or in the medication room. Medications in the medication room were to be stored in a secured, locked location, accessible only to designated staff members.

Review of the Medisystem Medication System policy last review January 17, 2017 stated refrigerated narcotic and controlled substances must be double locked in the refrigerator.

The Consultant Pharmacist (CP) was asked to read parts of the Medisystem Pharmacy Drug Inventory Control policy and the Medisystem Medication System policy related to controlled substances storage. The Inspector asked if the refrigerated locked black emergency box holding the injectable controlled substance was stored in a separate, double-locked stationary location in the locked medication room. The CP acknowledged that the policies did not speak to the 'stationary' aspect of narcotic storage and shared that there was a black locked box in the refrigerator that could be easily removed and was not stationary.

The Director of Care (DOC) acknowledged that the black storage box in the medication refrigerator was not stationary and a staff member could remove the controlled substance storage area from the medication room.

B) An Inspector observed the medication cart with a RPN present. The Inspector opened the bottom drawer of the medication cart and pulled the lid open from the narcotic storage area without a key. The RPN observed this and verified that the narcotic storage area in the medication cart was unlocked. The RPN shared that the drawer should be locked at all times and that it was not shut hard enough.

C) Inspectors observed the first floor medication room where the storage area for narcotics for destruction was located. An Inspector was able to easily pick up and remove the narcotic storage area from the shelf under the counter. Observation of the storage area determined that there was no hardware noted that secured the storage area to the shelf or wall. The RPN shared it was a new storage area when Medisystem Pharmacy took over and that Classic Care removed theirs and Medisystem supplied their own. The Executive Director and the Assistant Director of Care (ADOC) arrived immediately and verified that the narcotic storage area for controlled substances for destruction should be double locked and stationary.

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

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and compliance history a level three, as there was a history of previous related noncompliance. [s. 129. (1) (b)] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 133. 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.

Order / Ordre :

The licensee must take action to achieve compliance with O. Reg. 79/10, s.133 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 was 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 was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was 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).

Grounds / Motifs :

1. The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the following information, in respect of every drug that was ordered and received in the home:
1. The date the drug was 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 was ordered.
5. The name of the resident for whom the drug was prescribed, where applicable.
6. The prescription number, where applicable.
7. The date the drug was 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).

During the Resident Quality Inspection, four Critical Incidents were inspected related to missing controlled substances for an identified time period. The ordering and receipt of narcotics and controlled substances was reviewed.

The home's drug record was reviewed with a Registered Practical Nurse (RPN).

The RPN showed an Inspector a medication ordering form where pharmacy labels were applied or the order was handwritten by the nurse. The medications were then delivered with a packing list of medications received and the receiving nurse verified the medications and signed and dated the packing list form. The RPN acknowledged that there were receipts that were not signed and dated by registered staff and that there were also medications ordered where the handwritten orders did not contain the information required.

The ADOC shared that they were unsure of the drug record process for ordering and receiving medications, but that it appeared that some staff were signing and dating the order form and some were signing and dating the medication receipt "packing slip" from pharmacy. The ADOC acknowledged that there were receipts that were not signed and dated by registered staff for both non-controlled and controlled substances for multiple residents and that there were also medications ordered where the handwritten orders did not contain the information required. The ADOC also shared there was no order form completed for four identified residents and the controlled substances received from pharmacy had no staff signature or date on the medication receipt "packing slip" from pharmacy.

Review of the Medisystem "Ordering and Receiving Medications" policy last reviewed January 17, 2017, stated the "Drug Record Book" was a legal document of all medications ordered and received by the home. As such the drug record book must include all new orders, reorders and medications ordered and received by pharmacy.

Review of the Medisystem "Medication Reorder Sheet" documented 13 medications reordered from pharmacy with the following information missing:
• The date the drug was ordered was missing on two entries
• The name, strength and quantity of the drug was missing on eight entries
• The prescription number was missing on eight entries
• The date the drug was received in the home was missing on all 13 entries for reordering
• The signature of the person acknowledging receipt of the drug on behalf of the home was missing on all 13 entries for reordering.

The ADOC acknowledged that there was missing information required when ordering and receiving medications from pharmacy on the Medication Reorder Sheet.

The licensee has failed to ensure that a drug record was established, maintained and kept in the home for at least two years, in which was recorded the appropriate information in respect of every drug that was ordered and received from pharmacy.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 133.] (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Order / Ordre :

The licensee must take action to achieve compliance with O. Reg. 79/10, s.135 to ensure:
- That every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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.
- That all medication incidents and adverse drug reactions are documented, reviewed and analyzed; corrective action is taken as necessary; and a written record is kept of everything.
- That a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review are implemented; and a written record is kept of everything.

Grounds / Motifs :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and 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.

The home's medication incidents were reviewed for an identified time period.

A) A Medication Incident Report (MIR) was completed for an identified resident. The incident report did not identify the staff member who made the medication error. A controlled substance was not given to the resident and the type of error was documented as an omission. The incident report documented that the event was not communicated to the physician, the resident and/or Substitute Decision Maker (SDM), or the pharmacy service provider. There were no progress notes in PointClickCare (PCC) for the monitoring and assessment of the resident related to the omission of the controlled substance.

The Director of Care (DOC) shared that there was no documented evidence that the physician was made aware of the medication incident.

B) A Medication Incident Report was completed for a second identified resident. A medication was not removed as ordered and the incident was documented as an expired medication. The incident report documented that the event was not communicated to the pharmacy service provider. There were no progress notes or vital sign monitoring documented in PCC for the resident related to the expired medication.

C) A Medication Incident Report was completed for a third identified resident. The incident documented that medications were signed as given. The MIR documented that the physician was checked as notified, however for pharmacy it stated "online incident completed?" The Consultant Pharmacist shared pharmacy was not notified of the medication incident related to the identified resident. The DOC shared that when a paper hard copy of an incident was completed it should be faxed to pharmacy and then sent to the DOC.

D) A Medication Incident Report was completed for a fourth identified resident. The incident documented that the origin of the error was from pharmacy. The medication order was transcribed incorrectly in the electronic Medication Administration Record (eMAR) than what was documented on the blister pack. The Inspector asked why the medication order was not corrected in PCC at the time it was discovered as incorrect and the RPN acknowledged that it should have been changed and that the discrepancy created a nursing medication error twice on an identified date. There was no documentation of monitoring or assessment in PCC of the identified resident, related to this incident.

E) The home submitted two Critical Incident System (CIS) reports, 2662-000009

-16 and 2662-000010-16, to the Ministry of Health and Long-Term Care (MOHLTC) related to missing controlled substances for two identified residents. The DOC verified that there was no MIR completed for both residents, related to missing controlled substances.

Record review of the Revera LTC- Medication Incidents policy last reviewed July 31, 2016 stated if the medication incident was resident related, the nurse would assess the residents' condition and take immediate action as required. The physician, substitute decision-maker/family would be informed of all resident related incidents and the nurse would determine whether the physician/substitute decision-maker required notification immediately, within the next 12 hours or at the next visit.

The DOC shared that a record of the immediate actions taken to assess and maintain the resident's health should be in the progress notes in PCC, but also in Risk Management for any adverse reactions and in the Medication Incident Report online. The expectation was that for all residents involved in a medication incident, that a progress note documented the monitoring and assessment.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented with a record of the immediate actions taken to assess and maintain the resident's health.

2. The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed; corrective action was taken as necessary; and a written record was kept of everything.

A Medication Incident Report was completed for an identified resident. The incident documented that medications were signed as given. The MIR documented that the physician was checked as notified, however for pharmacy it stated "online incident completed?"

The DOC was asked for the name and designation of the staff involved and the DOC shared that they remembered talking to this person. The MIR follow up comments/corrective actions (DOC) documented "spoke to staff member who states the correct medication was given but not at the scheduled time. The DOC verified that there was corrective action taken and the registered staff member involved was spoken to but the RPN shared that they had never spoken to the DOC about this medication incident.

The licensee has failed to ensure that corrective action was taken as necessary related to the medication incident for an identified resident.

3. The licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; any changes and improvements identified in the review were implemented; and a written record was kept of everything.

The Executive Director (ED) provided copies of the medication incident reports (MIRs) for the last reviewed quarter. The ED shared that the last reviewed quarter was January to March 2017 and the last Professional Advisory Committee (PAC) meeting was in April 2017. The ED shared that the home switched pharmacy providers in March 2017 from Classic Care Pharmacy to Medisystem. The ED also stated that the July PAC meeting was cancelled due to poor attendance, verifying that the April PAC meeting was the last time the home conducted a quarterly review of the medication incidents.

Review of the "Professional Advisory Committee with Multidisciplinary Team Meeting Minutes" dated April 30, 2017, stated the "roundtable updates" included review of medication incidents. The meeting minutes documented that the medication incidents were pharmacy generated, that errors of omissions were common and incidents where Medisystems was at fault was due to a changeover in systems.

An Inspector requested copies of all medication incident reports completed during a specified time period and the DOC provided a copy of three medication incidents reported and the medication incidents were nursing errors. There was no documentation provided that a pharmacy error occurred during this time.

The Consultant Pharmacist (CP) acknowledged that they were present during the quarterly review of medication incidents at the PAC meeting in April 2017. The CP also verified that there had not been another quarterly review since April. The Inspector shared that the DOC stated that there were three MIRs that occurred during a specified time period and the Inspector reviewed the dates and associated resident names. The CP shared that there were also four other medication incidents during that time period and that they were submitted to Medisystem online. The four medication incidents were related to pharmacy

errors.

Review of the Medication Incident Reports during a specified time period included the following:
- A controlled substance was discarded before administration. The error was an omission by a Registered Nurse.
- A medication was not removed as ordered. The medication incident was a nursing error related to an expired medication.
- Controlled substances were missing for an identified resident.

Review of the Medisystem Medication Incidents policy last reviewed January 17, 2017, stated the medication incident reports would be analyzed by nursing administration, the pharmacy manager, and/or the consultant pharmacist to determine whether pharmacy and or nursing procedures required modification. The Pharmacy and Therapeutics Committee would also review a summary of all medication incidents at scheduled nursing home meetings to determine if corrective actions were necessary to prevent future harm.

Record review of the Revera LTC- Medication Incidents policy last reviewed July 31, 2016, stated:
"Medication incidents would be summarized, discussed and action plans developed as necessary (e.g. Professional Advisory Committee)".

The Executive Director acknowledged that a quarterly review was not undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in April 2017.

The Director of Care acknowledged that the quarterly review on April 30, 2017 of medication incidents during a specified time period did not include documentation related to the missing controlled substance and improper destruction of a controlled substance.

There was no documented evidence that a quarterly review was undertaken of all medication incidents and adverse drug reactions in the home since the time of the last review.

The severity of this area of non-compliance was determined to be a level two, potential for actual harm/risk, the scope was a level three, widespread and there was no history of previous related noncompliance. [s. 135. (563)

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

Ministére 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 16, 2018

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

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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 18th day of December, 2017

Signature of Inspector /
Signature de l'inspecteur :

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

Ministére 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

Name of Inspector /
Nom de l'inspecteur : MARIAN MACDONALD

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