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 11, 2017	2017_595604_0016	023774-17	Resident Quality Inspection

Licensee/Titulaire de permis

VILLA COLOMBO HOMES FOR THE AGED, INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

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

VILLA COLOMBO HOMES FOR THE AGED INC.
40 PLAYFAIR AVENUE TORONTO ON M6B 2P9

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

SHIHANA RUMZI (604), NATALIE MOLIN (652)

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 16, 17, 18, 19, 20, 23, 24, 25, 26, and 27, 2017.

During the course of the inspection, the following Complaint Intakes were inspected:
-Log #010035-17 – Complaint related to medication administration practices,
-Log #023753-17 – Complaint related to positioning and medication administration practices.

During the course of the inspection, the inspector(s) spoke with the Director of Resident Services (DRS), Directors of Nursing (DN), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Receiver, Housekeeping Aide (HA), Residents, Substitute Decision Makers (SDMs), and Private Sitters (PS).

During the course of the inspection, the inspector conducted a tour of the home, made observations of medication administration, staff and resident interactions, provision of care, conducted reviews of health records, and complaint logs, staff training records, reviewed meeting minutes of Residents' Council meetings, and reviewed relevant home's policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

5 WN(s)
1 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy "Narcotic and Controlled Drug Protocol", document number 09-01-03, with a reviewed date of August 2015, under "Guidelines" bullet number one, directed registered staff to ensure that narcotic and controlled drugs must be counted and reconciled at the beginning and end of each shift. Under "Shift Counting Procedure", bullet number one directs the staff that shift counts are to be conducted at the beginning of each shift by two nurses; the oncoming nurse and the outgoing nurse. The oncoming nurse verifies the count by actually counting. Each prescription is counted individually. Both nurses sign in the respective columns. The count must reconcile on the unit record and the individual record. Both nurses sign the "Unit Shift Count Sheet". Once count is completed, the oncoming nurse assumes responsibility for the keys to the narcotic box.

On an identified date, the inspector conducted a narcotic storage audit on an identified home area, with RPN #110. The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the "Narcotic and Controlled Drug Administration Record" (N&CDAR) sheet which was correct, however, the N&CDAR sheet had been signed as counted as being completed at an identified time by RPN #110.

An interview conducted with RPN #110, acknowledged he/she carried out the narcotic count on his/her own prior to an identified time of the day, and documented the count as

being carried out for the end of his/her shift. The RPN indicated he/she should have not carried out the shift count for narcotics on his/her own and confirmed that he/she did not follow the home's policy.

As the inspector found concerns during the initial narcotic storage audit observation the sample of the narcotic observation was expanded to other units in the home.

The inspector carried out a narcotic count audit on an identified home area, with RPN #118.The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet which was correct, however the N&CDAR sheet had been signed as counted for an identified time, by RPN #118.

An interview conducted with RPN #118 confirmed that two registered staff are to carry out the narcotic count at the end and beginning of each shift and the count is to be signed for at the time of the count. The RPN acknowledged he/she carried out the narcotic count independently for the identified residents and he/she signed the N&CDAR sheet as he/she attempts to gets organized for end of his/her shift. The RPN indicated he/she did not follow the home's policy and made an error in doing so.

The inspector carried out a narcotic count audit on an identified home area, with RPN #119. The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet. The inspector observed that at an identified time, the narcotic shift count was completed and signed by the outgoing RPN only and was missing the incoming nurses' signature on the N&CDAR sheet.

An interview conducted with RPN #119 confirmed that the home expects the narcotic count to be carried out at the end of the shift with the ongoing and oncoming nurse for the next shift. The RPN acknowledged that he/she carried out the narcotic shift count at an identified time, with the outgoing nurse but he/she forgot to sign the N&CDAR sheet after he/she verified the narcotic count was correct as he/she got busy on the floor and confirmed that this was not acceptable practice. The RPN indicated he/she did not follow the home's policy as to signing the N&CDAR sheet after he/she performed the narcotic count.

The inspector carried out a narcotic count audit on an identified home area, with RPN #121.The RPN called out the number of narcotics from the narcotics card and the

inspector compared the narcotic card count to the N&CDAR sheet which was correct however, the N&CDAR sheet had been signed as counted for an identified time of the day, by RPN #121.

An interview conducted with RPN #121 indicated that he/she is expected to carry out the shift count with another nurse who is coming to relive him/her from his/her shift. The RPN acknowledged he/she carried out the narcotic shift count on his/her own and he/she signed off the N&CDAR sheet on his/her own which is an unacceptable practice.

The inspector carried out a narcotic count audit on an identified home area with RPN #122.The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet.

An interview conducted with RPN #122 indicated the home's expectation was that the shift count for narcotics be carried out at the end of his/her shift with two nurses. The RPN stated he/she gets organized early for the end of his/her shift and acknowledged he/she conducted the narcotic shift count on his/her own and signed the count sheet. The RPN further stated this was not accepted practice.

Interviews were conducted with the Director of Resident Services (DRS) #101 and Director of Nursing (DN) #116 both indicated that two registered staff are expected to carry out the narcotic shift count at the end and beginning of each shift. The above narcotic audit observations where shown and discussed with the DRS and DN #116. The DRS and DN acknowledged that the RPNs assigned to the identified home areas did not follow the home's expectation related to carrying out the narcotic shift counts with two nurses and ensuring both nurses signed the N&CDAR sheet and with the correct time.

2. The home's policy "Narcotic and Controlled Drug Protocol", document number 09-01-03, with a reviewed date of August 2015, under "Guidelines" bullet number six directed the nurses to document on the N&CDAR each time he/she removes medication from the blister pack/container. Each column is filled with the required information and the nurse signs as the person administering.

The inspector carried out a controlled substance audit on an identified date and home area with RPN #119.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance count to the N&CDAR sheet. The inspector noted the controlled substance count for resident #041 was incorrect as the N&CDAR sheet indicated the resident had six identified

medication tables and the controlled substance card consisted of five tablets.
An interview conducted with RPN #119 acknowledged that he/she administered resident #041 his/her controlled substance at an identified time, and forgot to sign the N&CDAR sheet at the time of administration as per the home's policy.

The inspector expanded his/her controlled substance sample audit as he/she found concerns on an identified home area.

The inspector carried out a controlled substance audit on an identified date and home area, with RPN #124.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance card count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from controlled substance card for 11 identified residents.

An interview conducted with RPN #124 acknowledged that he/she did administer the controlled substance as ordered at the identified times to the 11 identified resident's and did not sign the N&CDAR sheet when he/she administered the controlled substance as per the home's policy.

The inspector carried out a controlled substance count audit on an identified date and home area, with RPN #120.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance card count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from controlled substance card for resident #054. Resident #054's N&CDAR sheet indicated 11 controlled substance tablets and the controlled substance card consisted of nine tablets.

An interview conducted with RPN #120 indicated he/she is to sign the N&CDAR sheet when he/she administers a controlled substance to a resident as per the home's policy. The RPN reviewed the N&CDAR sheet and controlled substance card for resident #054 and indicated that he/she administered the identified controlled substance to the resident at the two identified times, and forgot to sign the N&CDAR sheet with the correct count and he/she did not follow the home's expectations.

The inspector carried out a controlled substance audit on an identified date and home area, with RPN #123.The RPN called out the number of controlled substance from the controlled substance card and the inspector compared the controlled substance card

count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from the controlled substance card for resident #081. Resident #081's N&CDAR sheet indicated at an identified time and date, which was counted signed by two nurses indicating six tablets and the controlled substance card consisted of five tablets.

An interview conducted with RPN #123 indicated the N&CDAR sheet is to be signed when he/she administers a controlled substance on his/her shift to a resident as per the home's expectation. The RPN reviewed the N&CDAR sheet and controlled substance card for resident #081and indicated the residents was administered his/her identified controlled substance, but did not sign the N&CDAR sheet to reflect the current count. The RPN further stated he/she did not follow the home's expectation and he/she did not updated the N&CDAR sheet.

Interviews were conducted with the Director of Resident Services (DRS) #101 and Director of Nursing (DN) #116 both confirmed that registered staff are to immediately sign and update the N&CDAR sheet after administering a controlled substance. The DRS and DN reviewed the above controlled substance audit observations for the identified units. The DRS and DN acknowledged that the RPN's on the identified home areas did not follow the home's expectation related to signing the N&CDAR sheet as controlled substance are administered and did not follow the home's policies.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is potential. The inspector conducted controlled substance storage audits on the units as indicated on an identified date, which revealed that the end of shift controlled substance count was carried out between the identified hours. The controlled substance count which involved 55 residents' narcotics/controlled medications, the end of shift count was independently carried out by the RPN's on the identified units above, and at identified times, the shift count was not signed off by a second nurse for three residents. On the identified units above 13 residents controlled substance count was incorrect as documented on the N&CDAR.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that the home has had previous non-compliances issued related to the Long-Term Care Homes Act O. Reg. 79/10, r. 8. (1) (b):
2016_398605_0014, Resident Quality Inspection, April 14, 2016, - VPC

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. 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 :

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

The Ministry of Health and Long Term (MOHLTC) ACTIONline received two complaints from resident #021's Substitute Decisions Maker (SDM) #103. The initial complaint was received on an identified date, through the Info Line (IL), the SDM indicated on an identified date, the resident was seen by his/her medical specialist and was given a new prescription for his/her identified medication. The SDM stated that on an identified shift the nurse administered the identified medication to the resident and the nurse disagreed with the SDM related to the medication dose he/she administered to the resident. As a result of the home's investigation of the SDM's concern the nurse was terminated. The second complaint was received on another identified day through the IL, where the SDM stated registered staff administered the wrong dose of an identified medication on an identified time period, and had concerns related to resident #021's positioning.

A telephone interview was conducted with SDM #103 related to his/her complaints. The SDM indicated his/her main concern was related to the incorrect identified medication dose administered to resident #021 in an identified time period, and he/she brought the concern to the Charge Registered Nurses (CRN) #104 and the Registered Practical Nurses (RPN) #127 when he/she observed RPN #125 administer an identified

medication to the resident. The SDM stated RPN #125 was terminated shortly after he/she complained to the home.

A review of resident #021's "Physician's Digiorders" and consultation notes was carried out for an identified time period. The inspector found an order for an identified medication during an identified time period. The order stated to increase an identified medication when indicated. A review of the physician's digiorders revealed the order was transcribed and indicated the identified medication is to be used for an identified diagnosis of the resident.

A review of resident #021's Electronic Medication Administration Record (EMAR) was carried out for an identified time period. The EMAR indicated on two identified dates, when the residents' health condition changed the identified medication was not administered to the resident in accordance with the directions for use specified by the prescriber.

The inspector attempted to contact RPN #125 via telephone call with the number provided by the home and the number was no longer in use.

Interviews conducted with CRN #104 and RPN 127, acknowledged SDM #103 of resident #021 contacted them on an identified date, related to the concern he/she had. The concern was related to the incorrect dose of an identified medication administered by RPN #125 to the resident. Both CRN and RPN indicated they documented the concern and RPN #127 indicated he/she left a message for the manager to follow up but was unsure who the manager was as there was a change in management.

Interviews were conducted with the DRS #101 and DN #116 for unit three. DN #116 indicated as DN #126 was away from the home he/she covered the identified home area and was familiar with the unit and the residents. The DRS and DN #116 both indicated it was the home's expectation was that when an outside consultant sends an order the order is to be reconsolidated with the home's physician, entered into the EMARS, and administered as prescribed. The DRS and DN #116 reviewed the orders for the identified time period, consultation note, the identified medication order, and the EMAR records which was transcribed on an identified date. The DRS and DN #116 stated if the identified medication is to be administered twice a day the times for administration would be at two identified times of the day, and they both acknowledged the identified medication was not administered at the identified times and was not administered on two identified dates, as prescribed by the physician resident #021 when his/her had changes

in his/her health status.

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 ensure that drugs where administered to resident in accordance with the directions for use specified by the prescriber,, to be implemented voluntarily.

WN #3: 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 :

The licensee has failed to ensure that the resident was 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

Record review of resident #003's Personal Support Worker (PSW) documentation in the daily Care Flow Sheet supports Minimal Data Set (MDS) 2.0, with coding carried out during an identified time in 2017, revealed the resident experienced episodes of incontinence on 11 identified dates and shifts.

Record review of resident #003's PSW documentation in the "Daily Flow" sheet supported the MS 2.0 coding for an identified period and confirmed the resident experience episodes of incontinence also on three identified dates and shifts.

Record review of resident #003's written plan of care with an identified review date, revealed resident #003 was continent.

An interview conducted with PSW #117 revealed resident #003 was continent of his/her.

Interview with RN/ Resident Assessment Instrument (RAI) Coordinator # 118 revealed resident #003 experienced episodes incontinence in two identified time periods in 2017, and the expectation was that resident #003's continence needs would have been reassessed when resident #003 presented with changes to his/her voiding needs.

Interview with DN # 116 revealed the expectation of the home was that when the resident #003's continence care needs had changed the resident should have been reassessed.

WN #4: 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 :

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

On an identified date, the inspector carried out an initial tour of the home. During the tour on an identified unit at an identified time, the inspector was able to open an identified door which was found to be unlocked, and the door was equipped with a pin pad lock. The inspector observed Registered Practical Nurse (RPN) #102 to be standing with his/her medication cart across from the nursing station who arrived to the identified room.

An interview with RPN #102 indicated the identified room is to be kept locked at all times as the unit consisted of residents with identified health issues. The RPN acknowledged the door was unlocked. The inspector and RPN #102 entered the identified room, the room consisted of open boxes of syringes of 22, 25 gauge, and insulin needles, incontinent products, tubing for catheters, large and small nail clippers in blue denture cups. The RPN stated as the room consisted of sharp items and the door not being locked was a risk if a resident who may go into the room.

The inspector spoke with the DRS #101 who indicated all doors need to be locked if it is not a designated resident area. The DRS acknowledged that the identified room door was unlocked and was a risk to residents on the unit as the room consisted of sharps.

WN #5: 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 :

The licensee has failed to ensure that all areas where drugs are stored was restricted to persons who may dispense, prescribe, or administer drugs in the home, and the Administrator.

On an identified date, the inspector carried out an initial tour of the home. During the tour on an identified home area, the inspector observed the storage room to be open and Receiver #100 to be in the room stocking supplies with the boxes labelled "Government Supplies".

An interview with Receiver #100 was carried out and he/she indicated he/she receives all the government medication and supplies but does not dispense, prescribe or administer drugs in the home. He/she stated once the government medications are received he/she stocks the medication in an identified located in the home and once a week he/she does rounds on each home area and the nurses would give him/her a list of the government medication supplies needed for their home area. The Receiver indicated that he/she and some management staff of the home carried a master keys to access to the over stock medication supply.

An observation of the identified room was carried out by the inspector and the Receiver #100. The room contained various government medication supplies.

An interview with the Director of Resident Services (DRS) #101, indicated the home's government medication supply was located in an identified area of the home and it is received and delivered to the units by Receiver #100. The DRS acknowledged the government medication was not being stored in an area which is restricted to registered staff, doctors, and the administrator of the home.

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

Issued on this 11th day of December, 2017

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) :	SHIHANA RUMZI (604), NATALIE MOLIN (652)
Inspection No. / No de l'inspection :	2017_595604_0016
Log No. / No de registre :	023774-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 11, 2017
Licensee / Titulaire de permis :	VILLA COLOMBO HOMES FOR THE AGED, INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9
LTC Home / Foyer de SLD :	VILLA COLOMBO HOMES FOR THE AGED INC. 40 PLAYFAIR AVENUE, TORONTO, ON, M6B-2P9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tracey Comeau

To VILLA COLOMBO HOMES FOR THE AGED, 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) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

Within one week of receipt of this order the licensee shall prepare, submit and implement a plan to ensure that:

1) All registered staff are to be educated on the home's "Narcotic and Controlled Drug Protocol" policy.

2) Develop and implement a process to audit the Narcotic and Controlled Drug Administration Record (N&CDAR) in each home area to ensure the narcotic and controlled drug count is accurate.

Please submit the plan to shihana.rumzi@ontario.ca. within one week of receipt of this order by December 19, 2017.

Grounds / Motifs :

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

The home's policy "Narcotic and Controlled Drug Protocol", document number 09-01-03, with a reviewed date of August 2015, under "Guidelines" bullet number one, directed registered staff to ensure that narcotic and controlled drugs must be counted and reconciled at the beginning and end of each shift. Under "Shift Counting Procedure", bullet number one directs the staff that shift counts are to be conducted at the beginning of each shift by two nurses; the

oncoming nurse and the outgoing nurse. The oncoming nurse verifies the count by actually counting. Each prescription is counted individually. Both nurses sign in the respective columns. The count must reconcile on the unit record and the individual record. Both nurses sign the "Unit Shift Count Sheet". Once count is completed, the oncoming nurse assumes responsibility for the keys to the narcotic box.

On an identified date, the inspector conducted a narcotic storage audit on an identified home area, with RPN #110. The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the "Narcotic and Controlled Drug Administration Record" (N&CDAR) sheet which was correct, however, the N&CDAR sheet had been signed as counted as being completed at an identified time by RPN #110.

An interview conducted with RPN #110, acknowledged he/she carried out the narcotic count on his/her own prior to an identified time of the day, and documented the count as being carried out for the end of his/her shift. The RPN indicated he/she should have not carried out the shift count for narcotics on his/her own and confirmed that he/she did not follow the home's policy.

As the inspector found concerns during the initial narcotic storage audit observation the sample of the narcotic observation was expanded to other units in the home.

The inspector carried out a narcotic count audit on an identified home area, with RPN #118.The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet which was correct, however the N&CDAR sheet had been signed as counted for an identified time, by RPN #118.

An interview conducted with RPN #118 confirmed that two registered staff are to carry out the narcotic count at the end and beginning of each shift and the count is to be signed for at the time of the count. The RPN acknowledged he/she carried out the narcotic count independently for the identified residents and he/she signed the N&CDAR sheet as he/she attempts to gets organized for end of his/her shift. The RPN indicated he/she did not follow the home's policy and made an error in doing so.

The inspector carried out a narcotic count audit on an identified home area, with

RPN #119. The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet. The inspector observed that at an identified time, the narcotic shift count was completed and signed by the outgoing RPN only and was missing the incoming nurses' signature on the N&CDAR sheet.

An interview conducted with RPN #119 confirmed that the home expects the narcotic count to be carried out at the end of the shift with the ongoing and oncoming nurse for the next shift. The RPN acknowledged that he/she carried out the narcotic shift count at an identified time, with the outgoing nurse but he/she forgot to sign the N&CDAR sheet after he/she verified the narcotic count was correct as he/she got busy on the floor and confirmed that this was not acceptable practice. The RPN indicated he/she did not follow the home's policy as to signing the N&CDAR sheet after he/she performed the narcotic count.

The inspector carried out a narcotic count audit on an identified home area, with RPN #121.The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet which was correct however, the N&CDAR sheet had been signed as counted for an identified time of the day, by RPN #121.

An interview conducted with RPN #121 indicated that he/she is expected to carry out the shift count with another nurse who is coming to relive him/her from his/her shift. The RPN acknowledged he/she carried out the narcotic shift count on his/her own and he/she signed off the N&CDAR sheet on his/her own which is an unacceptable practice.

The inspector carried out a narcotic count audit on an identified home area with RPN #122.The RPN called out the number of narcotics from the narcotics card and the inspector compared the narcotic card count to the N&CDAR sheet.

An interview conducted with RPN #122 indicated the home's expectation was that the shift count for narcotics be carried out at the end of his/her shift with two nurses. The RPN stated he/she gets organized early for the end of his/her shift and acknowledged he/she conducted the narcotic shift count on his/her own and signed the count sheet. The RPN further stated this was not accepted practice.

Interviews were conducted with the Director of Resident Services (DRS) #101 and Director of Nursing (DN) #116 both indicated that two registered staff are

expected to carry out the narcotic shift count at the end and beginning of each shift. The above narcotic audit observations where shown and discussed with the DRS and DN #116. The DRS and DN acknowledged that the RPNs assigned to the identified home areas did not follow the home's expectation related to carrying out the narcotic shift counts with two nurses and ensuring both nurses signed the N&CDAR sheet and with the correct time.

2. The home's policy "Narcotic and Controlled Drug Protocol", document number 09-01-03, with a reviewed date of August 2015, under "Guidelines" bullet number six directed the nurses to document on the N&CDAR each time he/she removes medication from the blister pack/container. Each column is filled with the required information and the nurse signs as the person administering.

The inspector carried out a controlled substance audit on an identified date and home area with RPN #119.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance count to the N&CDAR sheet. The inspector noted the controlled substance count for resident #041 was incorrect as the N&CDAR sheet indicated the resident had six identified medication tables and the controlled substance card consisted of five tablets.
An interview conducted with RPN #119 acknowledged that he/she administered resident #041 his/her controlled substance at an identified time, and forgot to sign the N&CDAR sheet at the time of administration as per the home's policy.

The inspector expanded his/her controlled substance sample audit as he/she found concerns on an identified home area.

The inspector carried out a controlled substance audit on an identified date and home area, with RPN #124.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance card count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from controlled substance card for 11 identified residents.

An interview conducted with RPN #124 acknowledged that he/she did administer the controlled substance as ordered at the identified times to the 11 identified resident's and did not sign the N&CDAR sheet when he/she administered the controlled substance as per the home's policy.

The inspector carried out a controlled substance count audit on an identified date and home area, with RPN #120.The RPN called out the number of the controlled substance from the controlled substance card and the inspector compared the controlled substance card count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from controlled substance card for resident #054. Resident #054's N&CDAR sheet indicated 11 controlled substance tablets and the controlled substance card consisted of nine tablets.

An interview conducted with RPN #120 indicated he/she is to sign the N&CDAR sheet when he/she administers a controlled substance to a resident as per the home's policy. The RPN reviewed the N&CDAR sheet and controlled substance card for resident #054 and indicated that he/she administered the identified controlled substance to the resident at the two identified times, and forgot to sign the N&CDAR sheet with the correct count and he/she did not follow the home's expectations.

The inspector carried out a controlled substance audit on an identified date and home area, with RPN #123.The RPN called out the number of controlled substance from the controlled substance card and the inspector compared the controlled substance card count to the N&CDAR sheet. As the controlled substance count started the controlled substance count on the N&CDAR sheet was different from the controlled substance card for resident #081. Resident #081's N&CDAR sheet indicated at an identified time and date, which was counted signed by two nurses indicating six tablets and the controlled substance card consisted of five tablets.

An interview conducted with RPN #123 indicated the N&CDAR sheet is to be signed when he/she administers a controlled substance on his/her shift to a resident as per the home's expectation. The RPN reviewed the N&CDAR sheet and controlled substance card for resident #081and indicated the residents was administered his/her identified controlled substance, but did not sign the N&CDAR sheet to reflect the current count. The RPN further stated he/she did not follow the home's expectation and he/she did not updated the N&CDAR sheet.

Interviews were conducted with the Director of Resident Services (DRS) #101 and Director of Nursing (DN) #116 both confirmed that registered staff are to immediately sign and update the N&CDAR sheet after administering a controlled

substance. The DRS and DN reviewed the above controlled substance audit observations for the identified units. The DRS and DN acknowledged that the RPN's on the identified home areas did not follow the home's expectation related to signing the N&CDAR sheet as controlled substance are administered and did not follow the home's policies.

The home is being served an order as the severity of the non-compliance and the severity of harm and risk is potential. The inspector conducted controlled substance storage audits on the units as indicated on an identified date, which revealed that the end of shift controlled substance count was carried out between the identified hours. The controlled substance count which involved 55 residents' narcotics/controlled medications, the end of shift count was independently carried out by the RPN's on the identified units above, and at identified times, the shift count was not signed off by a second nurse for three residents. On the identified units above 13 residents controlled substance count was incorrect as documented on the N&CDAR.

The scope of the non-compliance is widespread.

A review of the home's compliance history revealed that the home has had previous non-compliances issued related to the Long-Term Care Homes Act O. Reg. 79/10, r. 8. (1) (b):
2016_398605_0014, Resident Quality Inspection, April 14, 2016, - VPC
2015_340566_0006, Resident Quality Inspection, Apr 17, 2015, - WN [s. 8. (1) (b)]
(604)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 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 11th 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 : Shihana Rumzi

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