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
Jun 12, 2018	2018_538144_0018	010462-16, 030215-16, 002408-17, 010233-17	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
120 Adelaide Street West, Suite 425 5015 Spectrum Way, Suite 600, Mississauga ON L4W 0E4 TORONTO ON M5H 1T1

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

Riverside Place
3181 Meadowbrook Lane WINDSOR ON N8T 0A4

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

CAROLEE MILLINER (144)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 4, 5, 6 and 7, 2018.

The following intake information and critical incident (CI) report inspections were completed with this inspection:
#002408-17, CI 2972-000003-17 related to duty to protect
#010233-17, CI 2972-000005-17 related to the medication management system
#010462-16 related to duty to protect and transferring and positioning
#030215-16, CI 2972-000011-16 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with two residents, the Executive Director, Director of Care, Assistant Director of Care, one Registered Nurse, two Registered Practical Nurses and two Personal Service Workers.

During the course of the inspection, the the inspector reviewed eight resident clinical records, relevant policies and procedures, minutes to the Professional Advisory Committee Meeting, the narcotic destruction bin and observed resident to resident and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

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 is developed in the home that provides for the ongoing disposal of a resident's drugs where the prescriber attending the resident orders that the use of the drug to be discontinued.

The home’s Medication Disposal - Controlled Substances Policy last reviewed December 2016, included the following directive that registered staff were required to follow during disposal of a narcotic medication:

"6. The resident’s individual count sheet is wrapped around and/or affixed to the controlled substance for destruction which in the presence of both registered personnel is witnessed being placed in the double-locked location designated for controlled substances awaiting disposal."

Review of one critical incident revealed that during the narcotic drug destruction process, it was discovered that there were medication tablets missing from the discontinued narcotic drug destruction box.

Review of the drug count sheet revealed the narcotic medication had been discontinued by the Physician on a specific date. The drug count sheet further revealed that two registered staff had signed the controlled drug count sheet on the same date that the medication was discontinued and that the registered staff documented the quantity of medication tablets being discontinued.

The ADOC confirmed with the inspector that during the narcotic drug destruction process the drug count sheet was located in the drug destruction bin and identified the number of medication tablets that remained however, the medication tablets were not in the discontinued bin.

The Executive Director advised the inspector that an investigation was implemented immediately and the local police services contacted.

The ED said that during the investigation, all medication rooms were searched and the drug destruction box inspected. .

The ED shared that the registered staff interview process for the incident occurred approximately six weeks after the medication was discontinued by the Physician.

The ED said that the registered staff that signed the drug count sheet indicated to them (ED) during an interview that they followed the home's policy related to the disposal of controlled substances.

The ED explained that one day after the incident, the home proceeded with their planned transition to an alternate pharmacy service provider and that all registered staff received mandatory education from the new pharmacy provider related to the drug destruction process.

The inspector observed that the narcotic discontinued bin was wooden, stored in a locked office inside a cupboard and secured to the bottom of the cupboard. The bin presented with two key locks. Different keys were required to open each lock.

The DOC said that they (DOC), the ADOC and registered personnel were the only individuals that could access the narcotic destruction bin and that narcotic drug destruction with the pharmacist now occurred on a monthly basis.

The ED advised the inspector that a discipline did not result related to this incident due to lack of evidence and that the incident has not recurred.

The licensee has failed to ensure that the required drug destruction policy was complied with. [s. 8. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where any required plan, policy, protocol, procedure, strategy or system the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, to be implemented voluntarily.

WN #2: 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 and locked.

On one identified date, the inspector entered the unlocked medication room on one identified resident home area. The inspector accessed the drawers on the unlocked medication cart located in the medication room. At the same time, the point click care (PCC) software program on the medication cart displayed dashboard information related to three resident's.

There were no registered staff in the vicinity of the medication room and within the inspector’s visual field. Two residents were observed by the inspector seated in wheelchairs at the nurse’s desk outside of the medication room and one resident was observed walking in the corridor alongside the nurse’s desk.

One identified Registered Nurse (RN) entered the medication room and advised the inspector they had left the area to attend to a resident.

The identified RN told the inspector that the home’s policy was to lock the medication room when it was being left unattended and to ensure the medication cart was locked when it was not in use.

The Director of Care said it was their expectation that the medication cart was locked when not in use, the door to the medication room also locked when registered staff left the area and the PCC program on the medication cart closed.

The DOC further said that the identified RN should have locked the medication cart and closed the medication room door before they left the medication room.

The licensee failed to ensure that the medication cart was secured and locked. [s. 129. (1) (a)]

Additional Required Actions:

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

Issued on this 12th day of June, 2018

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

Original report signed by the inspector.