Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 1, 2019	2019_538144_0016	029768-18	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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): March 28, 2019.

The following intake was inspected within this inspection:
Log #029768-18, CIS #2972-000020-18 related to drug destruction and disposal.

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

During the course of the inspection, the inspector observed the narcotic destruction box and reviewed the home's narcotic and controlled drug surplus record form, the narcotic and controlled substance administration record for one resident and the home's narcotics and controlled drugs management policy.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 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:

Ontario Regulation 79/10, r.136(d)(1) states: 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 identification, destruction and disposal of, a resident's drugs where, the prescriber attending the resident orders that the use of the drug be discontinued.

The home's Narcotics and Controlled Drugs Policy on review, included the following directives related to discontinued narcotics and controlled substances:

"The Nurse will bring the discontinued narcotic and controlled drugs, along with the Individualized Resident's Narcotic and Controlled Drug Count Sheet, to the DOC/designated Nurse."

"The DOC/designated Nurse and the second Nurse will count the drugs, and all responsible parties will sign the count sheet to verify that the information is correct."

A critical incident report related to controlled substances was reviewed by the inspector.

The report included that during one medication drug destruction by the Director of Care (DOC) and Pharmacist, it was observed that there were no medication tablets included with one resident's medication card.

The Executive Director (ED) and the Assistant Director of Care (ADOC) told the inspector that during drug destruction on one identified date by the Director of Care (DOC) and Pharmacist, it was discovered that the medication card for one resident did not include a specified amount of medication tablets.

Review of the resident's individualized drug count record revealed that the medication was discontinued by the physician on an identified date.

One Registered Nurse (RN) documented in the "count" column of the individualized drug record that there were a specified amount of medication tablets left in the medication card.

The ADOC said that the individualized drug count record for the resident remained stored in the locked bin in the medication cart until the date of drug destruction after the medication had been discontinued by the physician.

One identified Registered Practical Nurse (RPN) and one identified RN had signed the individualized drug count record and indicated the specified number of medication tablets that remained in the medication card.

An undated photocopied medication card for the resident's discontinued medication revealed there were no medication tablets in the card.

The ED and ADOC advised that the photocopy of the empty medication card was taken by the DOC during drug destruction with the Pharmacist when it was discovered the card did not include medication tablets.

The ED advised that the home's investigation of the incident concluded that one RPN and one RN did not follow the home's policy.

The ED and ADOC said that the involved registered staff had not checked the number of medication tablets left on the medication card when the drug count was completed and documented on the drug record, the number of tablets left during the previous drug count.

Review of the individualized drug record for the resident revealed that at two different times on one specified date, there were similar amounts of medication tablets in the medication card.

Since the incident reported in the CI, registered personnel are required to jointly make a photocopy of the appropriate resident's drug count record and provide the photocopy to the ADOC.

The original drug count sheet continues to be attached to the discontinued medication card.

The ED and ADOC reconfirmed with the inspector, the above incident and follow-up action by the home. [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 o ensure that where the Act or Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy was complied with, to be implemented voluntarily.

Issued on this 1st day of April, 2019

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

Original report signed by the inspector.