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


Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Hamilton Service Area Office
119 King Street West, 11th Floor
HAMILTON, ON, L8P-4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest, 11iém étage
HAMILTON, ON, L8P-4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255


## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 8, 2014 | 2014_201167_0009 | H-000395-13 | Critical Incident System |

**Licensee/Titulaire de permis**

ST. JOSEPH'S HEALTH SYSTEM
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

ST JOSEPH'S VILLA, DUNDAS
56 GOVERNOR'S ROAD, DUNDAS, ON, L9H-5G7

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

MARILYN TONE (167), SUSAN PORTEOUS (560)

**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 10 and 11, 2014.

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care (ADOC), registered staff and personal support worker staff.

During the course of the inspection, the inspector(s) conducted a review of the health record for an identified resident, reviewed Medication Administration Records (MARs), Shift Change Monitored Medication Count records, individual Monitored Medication records, investigation notes completed by the home, relevant policies and procedures, critical incident report related to the incident and conducted a tour of the medication room and carts.

The following Inspection Protocols were used during this inspection:
Medication

Findings of Non-Compliance were found during this inspection.

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| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 did not ensure that the home's policy, protocol or procedure related to narcotic inventory and count was followed by staff.

A) On two identified dates in 2013, it was noted that a narcotic medication was missing on each of the day shifts when the narcotic count was done.
B) During the home's investigation, it was found that the registered staff member who had worked both of the previous night shifts admitted to having left the medication keys on top of a medication cart in the medication room so they did not have to carry so many keys.
C) The ADOC confirmed that staff were expected to carry the medication keys with them at all times. The home's policy related to Narcotics and Controlled Substances was revised in 2013 to include the following direction after the two instances of missing narcotics on the identified dates. The policy was revised to include" Narcotic keys should be on your persons (registered staff) at all times during your shift and handed directly to the registered staff for the next shift".
D) It was also noted that the same policy provided the following direction to registered staff " Each shift, the narcotic supply is counted by two registered staff and the Narcotic Count Sheet is signed".
E) It was noted during a review of the Narcotic Count Sheets for an identified month in 2013 that there was only one signature present for narcotic counts completed for the evening to night shift on seven identified dates in the identified month and one date in the next month indicating that only one registered staff did the count.
It was also noted that the narcotic count for the day to evening shift for an identified date in 2013 had only one signature and the night to day shift count for an identified date had only one signature.
F) The ADOC confirmed that it was the expectation that a narcotic count was always completed by two registered staff and that both staff must sign that they have completed the count. [s. 8. (1)]

*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 the Act or this Regulation requires the licensee of a long-term care home have 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, b) is complied with., to be implemented voluntarily.***

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**WN #2: 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).**

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**Findings/Faits saillants :**

1. The licensee did not ensure that the Director was informed of the following incident in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

A) During the narcotic count completed by registered staff on two identified day shifts in 2013, it was noted that one narcotic medication was missing each day. On both occasions this was reported to the Assistant Director of Care (ADOC).
B) The Director was not notified of the incident until eight days after the first incident of missing narcotic was identified. [s. 107. (3) 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 the Director is informed of the following incident in the home no later that 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., to be implemented voluntarily.*

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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).

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Findings/Faits saillants :

1. The licensee did not ensure that 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) It was noted by the registered staff working on the day shift when the narcotic count was done on on two identified dates in 2013 that there was one narcotic medication missing each of those day. The discrepancy was reported to the ADOC on each occasion.
B) During a review of the Narcotic Count sheets, it was confirmed that one narcotic medication was missing on both of the identified dates when the count was completed on the day shift and indicated that the medication had gone missing on the previous night shifts.
C) During the home's investigation into the incident, it was confirmed by the registered staff member who was working the night shift on both occasions that they had left the medication keys on top of one of the medication carts in the medication room so that they did not have to carry so many keys.
It was confirmed by the ADOC that all registered staff working have a key to the medication rooms.
This practice would result in failure to provide a double-locked environment for the narcotic bin as the narcotic keys would available to any other registered staff who entered the medication room. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within a locked medication cart., to be implemented voluntarily.***

Issued on this 8th day of April, 2014

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