Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 21, 2020	2020_526645_0006	012507-20, 012635-20, 012645-20, 012673-20, 012681-20, 012685-20, 012690-20, 012899-20, 013994-20, 014693-20, 016186-20, 017037-20	Critical Incident System

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 Markham ON L3R 0E8

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

Camilla Care Community
2250 Hurontario Street Mississauga ON L5B 1M8

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

DEREGE GEDA (645), JULIEANN HING (649), ORALDEEN BROWN (698)

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): July 16, 17, 20, 21, 22, 23, 24, 29, 30, 31, August 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 18, 19, 20, 21, 24, 25, 26, 27, 28,

31, September 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28 and 29, 2020.

This inspection was completed to inspect upon the following intake logs:
012507-20 - for Critical Incident System (CIS) report number 2472-000027-20, related to prevention of abuse and neglect;
012635-20 - for CIS report number 2472-000024-20, related to prevention of abuse and neglect;
012899-20 - for CIS report number 2472-000029-20, related to prevention of abuse and neglect;
012645-20 - for CIS report number 2472-000028-20, related to unexpected death of a resident;
012673-20 - for CIS report number 2472-000022-20, related to reports regarding critical incidents and hospitalization change in condition;
012690-20 - for CIS report number 2472-000026-20, related to prevention of abuse and neglect;
012681-20 - for CIS report number 2472-000023-20, related to prevention of abuse and neglect;
014693-20 - for CIS report number 2472-000037-20, related to fall prevention and management;
012685-20 - for CIS report number 2472-000025-20, related to hospitalization change in condition;
013994-20 - for CIS report number 2472-000032-20, related to prevention of abuse and neglect;
016186-20 - for CIS report number 2472-000045-20, related to reports regarding critical incidents and infection prevention and control program and
017037-20 - for CIS report number 2472-000051-20, related to medication administration and prevention of abuse and neglect.

Eight Written Notifications (WNs) identified in a concurrent complaint inspection #2020_526645_0007 (Log # 013327-20), are issued in this report, and the legislation are as follows: r. 107. (4) 1, r. 131. (2), r. 229. (5), r. 26. (3) 15, s. 24. (1), s. 23. (1) (a), s. 19. (1) and r. 8. (1) (b).

During the inspection, Inspector #645 identified additional grounds for compliance orders(COs) issued under inspection #2020_556168_0013, and written notifications (WNs) are issued under s. 131(2), 229(1), s 8 and S. 19, within this report.

During the course of the inspection, the inspector(s) spoke with the acting

Executive Director (aED), Behavioural Supports Ontario/Communications lead, Director of Care (DOC), Assistant Directors of Care (ADOC), Office Manager, Environmental Services Supervisor (ESS), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspectors observed provision of care, services and supplies; reviewed records including but not limited to relevant training records, policies and procedures, meeting minutes, line listings, logs, resident's clinical health records, schedules and investigative notes.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Medication
Pain
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **13 WN(s)**
- **4 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Prevention of Abuse and Neglect of a Resident policy, # VII-G-10.00, Current Revision: April 2019, was reviewed, and indicated the following:
All team members are required to report immediately any suspected or known incident of abuse or neglect to the provincial health authorities and the Executive Director or designate in charge of the care community;
- the Executive Director or designate, at the time of immediate notification, initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
- the alleged neglect/abuser is also asked to write, sign, and date a statement of the event
- the written statements are obtained as close to the time of the event as possible; and
- the Executive Director or designate interviews the resident, other residents, staff members and/or persons who may have any knowledge of the situation.
- Immediately notify the Ministry and/or the Police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence.
- the Executive Director or designate interviews those persons completing the statements after the statement has been written.
- all investigative information is kept in a separate report from the resident's record.

The home's Abuse policy defined physical abuse as : a)The use of physical force by anyone, other than a resident, that causes pain or may cause pain, b) Over-medication, withholding medication, or medicating of a resident when it is not medically necessary to do so and c) Any undue physical force by team members when providing care to a resident.

The home's policy titled Detecting Signs of Diversion, Policy #VII-E-10-10(a) last revised May 2019, described signs of narcotic diversion but not limited to the following:
- Evidence of frequent tampering and substitution of narcotics
- Frequent disappearances to bathroom or dirty utility room for prolonged periods
- Unusual wasting medication pattern
- Progressively poor charting and residents' assessments
- Declining interpersonal relationships
- Arriving early to work and staying late after shift

- High achievers
- Unusual wasting medication pattern
- Frequent breaking of ampules and discrepancies and
- Narcotics waste not signed.

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care (MLTC) regarding an alleged incident of abuse and neglect involving eighteen (18) residents. These residents were given narcotic medications by RN #127 when they didn't need it. There were multiple allegations of narcotic diversion by the same staff member and the allegations were ongoing since 2016. In 2016, PSW #128 witnessed RN #127 self injecting/administering narcotic medications that were prescribed for residents in a resident's washroom, and brought the concerns to the home management team. The PSW reported the incident again to the new management team in August 2020, as these concerns were still ongoing, and believed no actions were taken to protect residents after they reported the allegation in 2016. RN #127 is still employed at the home and was providing care until May 2020. Review of the records indicated that the MLTC and the police were not notified regarding the allegation of abuse and narcotic diversion until August 2020.

Review of the Human Resource (HR) file for RN #127 indicated that the previous management team was aware of the allegations in 2016 and there had been ongoing concerns regarding narcotic medication administrations. The HR document indicated that there had been multiple suspicious concerns and narcotic administration errors in 2016, 2017, 2018 and 2019. In August 2020, during an unrelated incident investigation by the current management team, PSW #128 brought forward the ongoing concerns they had regarding misappropriation of residents' drugs and neglect of residents. Inspector #645 also interviewed the PSW. During the interview, the PSW indicated that they observed the RN self injecting medications on two different occasions. They indicated that the first time they observed RN #127 self injecting was in 2016 and the most recent incident was in March 2020. The PSW indicated that in 2016, when they walked into a resident #015's room, they observed RN #127 lifting their shirt in the resident's washroom and attempting to self inject the medication. The washroom door was ajar and when the RN saw them walking in, they appeared to be nervous and the needle fell from their hand. The PSW walked out of the room as they couldn't believe what they saw, and returned to the room a few minutes later. When they returned to the room, they observed the RN forcefully holding resident #015's body part and the resident was screaming and shaking vigorously. The PSW indicated that the RN seemed frozen, confused and high. The PSW grabbed the RN by their hand to free the resident. The PSW knew the resident was on a

prescribed narcotic medication, was worried about the resident's safety and suspicious of drug diversion. The HR file indicated that the PSW notified the home management in September 2016. The PSW stated that since then, they observed a pattern of behaviours to suspect narcotic drug seeking behaviours in the year of 2017/18. For example, behaviours such as paying extra attention to residents who were taking narcotic medications, removing sharp disposal containers where staff members discard narcotic wastage and asking other staff members to save narcotic wastage for them. For instance, RN #129 would save narcotic wastage for RN #127. The PSW indicated that this had been an ongoing issue since 2016 and staff members knew about RN #127's behaviours, but never told the management team as they were afraid of reprisal. The PSW indicated that they reported these concerns in 2016 and on an ongoing basis but previous management did not take any actions, hence the behaviours continued. The PSW indicated that the management team labelled them as a trouble maker because they reported the RN. When they reported the incident on March 2020, where they observed the RN self injecting in the resident's washroom for the second time, they were advised by the previous ED to stop reporting as they were trying to clear RN #127's name. The PSW indicated that there was ongoing bullying towards them by RN #127 after they reported them in 2016. They indicated that they directed their complaints to the union-representative as management team did not welcome their reporting.

During the record review of the HR file, Inspector #645 was able to find a summary note written in September 2016, indicating actions taken by the home regarding narcotic diversion, but there were no interview documentations available. No evidence to support if the appropriate authorities were notified for the alleged residents abuse and neglect, narcotic diversion, and misappropriation of residents' drugs. The note indicated that the home suspected inappropriate dispensing/use of narcotic and narcotic diversion, and spoke with PSW #128, RN #127, and RN #129 in September 2016. RN #127 denied the allegations, but was disciplined, and coaching was provided on safe narcotic administration and dispensing processes. The notes also indicated that RN #127 used an identified type of needle to administer narcotics and was recommended not to use the needle, as it was not a safe method to administer narcotics for residents. The notes also indicated that RN #129 admitted that they often left open narcotic injection vials for the on-coming RN #127 to waste, instead of wasting them with the other registered staff on the same shift. The notes indicated that RN #129 worked with three other registered staff on night shift but would choose to wait for RN #127 on the next shift. RN #129 was disciplined for their actions and education provided.

Further review of the HR records indicated that there had been multiple on-going

concerns regarding narcotic medications dispensing, administering, ordering and wasting practice by RN #127. The concerns are as follows:
- In the year of 2018, the HR notes indicated that RN #127 accessed the emergency drug box (ER-Box)13 times to dispense narcotic medications, which was more frequently than the other registered staff members. Review of the ER-Box drug monitoring sheet indicated that the total number of times the ER-Box was accessed for narcotics in 2018, by all registered staff, was fifteen, and thirteen of them were accessed by RN #127.

- Summary notes from 2016, indicated that other registered staff alleged that RN #127 administered narcotic medications for residents when they don't need it and without proper pain assessment: the note indicated that RN #127 dispensed and administered narcotics to there identified residents. The notes indicated that pre or post pain assessments were not completed . No indications as to why the pain medication was given. Staff alleged that the RN administered narcotics most of the time.

- Review of a complaint letter stored in the HR file from a family member of resident #033 indicated that the family was upset because the resident was given narcotic medication. The family requested the medication to be stopped immediately. Review of the narcotic sheet indicated RN #127 administered the medication to the resident. Review of the progress note on the same day indicated that there was no pain assessment completed. There was no evidence to support if non-pharmacological approaches were attempted. No documents were available to support the reason for administering the narcotic. Review of the clinical notes indicated no documentation and no signatures on the e-MAR. There was no indication of pre or post pain assessment, and no documentation in resident #033's plan of care. The progress notes indicated that RN #127 documented an assessment as a late entry a few days later after the home management raised the resident's family concern to RN #127. The RN indicated that they administered the narcotic medication because the resident had an identified type of illness. The notes indicated that the RN was disciplined, and educated on safe narcotics administration. The home's investigation notes indicated that the RN neglected the resident.

- Review of an HR summary note in 2019, indicated that RN #109 reported to the previous DOC that they found a syringe filled with an unidentified clear substance, stored in a residents' chart area between papers. RN #109 was suspicious that the syringe was filled with injectable narcotic fluids. The note indicated that RN #127 co-signed the narcotic waste with RN #126 and RPN #108. The note indicated that ADOC #105

investigated the incident but couldn't substantiate the allegation of narcotic diversion. There were no written statements from RN #127, RPN #108 and RN #126 available. Inspector was unable to find staff interviews and investigation documents.

- SUSPICIOUS act: 12 staff members signed a petition, in September 2018, to inform the home about suspicious actions of RN #127. The petition had the name of twelve staff members with their signatures. There were no written statements from the staff members to indicate the nature of their suspicion, and no interviews or investigation were conducted.

- Review of the Physician order in 2015, indicated that RN #127 received a new narcotic medication order for resident #011. Review of the ER box narcotic sheet indicated that the medication was dispensed and administered, and the left over medication was wasted. The records indicated that RN #127 did not sign on the e-MAR. Inspector #645 was unable to verify if the medication was administered to the resident.

- Review of the clinical notes in October 2019, indicated that resident #006 was exhibiting an identified type of behaviour and was unable to settle down. The Physician order on October 2019, indicated that RN #127 received a telephone order for a narcotic medication to help settle the resident. The notes indicated that the medication was given by RN #127. Review of the e-MAR on the same day, indicated that the e-MAR was not signed. Inspector was unable to verify who co-signed the narcotic waste with RN #127. There was no corresponding assessment completed to indicate the cause of the behaviours and if the medication was effective after administration.

- Review of the HR note in July 2018, indicated that a narcotic medication was administered to resident #016 on two occasions. The note indicated that RN #127 dispensed and administered the medications without a second nurse co-signing the wastes on both occasions. The note also indicated that RN #127 did not sign on the e-MAR. Inspector #645 was unable to verify if the medication was administered to the resident. A disciplinary follow up note in September 2018, indicated that RN #127 was instructed to sign the e-MAR, the individual narcotic sheet and re-educated on pre/post pain assessments.

- In June 2016, the home management (previous ED) received a complainant from RN #104 regarding suspicious behaviours regarding narcotic diversion. RN #104 indicated that RN #127 was giving narcotic injections more frequently than other medications. RN #104 indicated that residents were able to take medications orally, but the RN often

chose to administer narcotic injectables. RN #127 accessed the emergency drug box frequently when they received a new order. RN #104 also indicated that RN #127 took the sharp containers that had discarded narcotics to the utility room which was not a duty of the registered staff. RN #128 saved narcotic wastage to discard with RN #127 instead of other nurses on the unit. RN #104 suspected drug seeking behaviours as the RN appeared different at times, and RN #104 advised the ED to get the appropriate authorities involved and provide support for RN #127. RN #104 was concerned for residents' safety as they believed that RN #127 was administering narcotic medications to residents who did not need it.

- A performance improvement meeting was held with RN #127 in 2016 and education was provided. Email conversations between the previous DOC and the ED, in March 2016, indicated concerns with RN #127's interpersonal relationship, attitude and insubordination in the work place.

- In February 2014, missing Narcotic was reported to the home management team. The notes indicated that the DOC interviewed RN #127 and RPN #110. Inspector #645 found no investigation notes or staff interviews regarding the missing narcotic and unable to verify the outcome of the investigation.

- In March 2014, an email correspondence between the previous DOC and management team indicated the following: staff were suspicious about narcotic diversion; RN #127 gave per-required-needed (PRNs) narcotics to residents while other staff are on break; RN #127 emptied sharp containers, and night staff left narcotics for the RN to waste. The DOC spoke with RN #107 and RN #135 regarding the missing narcotics. The email also indicated that RPN #136 would leave narcotic wastage for RN #127 to waste and when asked, RPN #136 indicated that RN #127 instructed them to do so. The HR note indicated that registered staff were advised not to give the narcotics key to RN #127 and always to keep the key with them. In the same email, the DOC indicated that there was no reason to investigate these allegations. Inspector #645 found no investigation notes for the allegation and unable to verify the outcome of the investigation. There were no written, and signed statements from the staff members describing the event. Inspector was unable to identify which residents were given narcotics when the nurses went on break. There was no record of staff interviews or investigations completed.

- The HR document from December 2015, indicated that a narcotic medication was administered to resident #004 but the wastage was not witnessed or co-signed by a registered staff. This medication was administered/dispensed by RN #127. On the

document, RN #127 indicated RN #117 witnessed the wastage. The document indicated that RN #117 did not witness the waste and didn't co-sign for the above medication. There were no interviews or investigative documents available to provide details about the incident, outcome of the investigation and interventions considered to mitigate the concern. The document also indicated that a telephone order was obtained by RN #127 for the narcotic, but the medication was not transcribed, and the administration was not documented on the e-MAR. The DOC and RN #117 also questioned the need for the narcotic injection as the resident was taking oral medications at the time. The practice was identified by the DOC as inconsistent with Best Practice Guidelines for least invasive procedures. There was no corresponding assessment available to verify the need for the narcotic medication.

- Review of the HR document and the narcotic sign in/out sheet in February 2016, indicated that a narcotic medication vial was dispensed and administered to resident #010. The HR note indicated that it was unclear who witnessed the wastage. Both signatures on dispensing and waste witnessing narcotic sheet sections were identical and signed by RN #127. This medication was administered/dispensed by RN #127 and when asked, RN #127 stated that the waste was witnessed and co-signed by RPN #110. A note in the HR file indicated that RPN #110 did not witness or co-sign on the narcotic sheet, and the signature on the sheet was not their signature. The medication administration was not signed on the e-MAR. Inspector reviewed the signatures on the narcotic sheet, and both signatures were identical with RN #127's signature. On the same day, RN #127 dispensed another narcotic medication vial and administered to resident #010. Similar to the above incident, both signatures were identical. The e-MAR was not signed.

- Review of the narcotic sign in/out sheet in February 2016, indicated a narcotic medication vial was dispensed under resident #011's name. This medication was administered/dispensed by RN #127. The narcotic sheet indicated that the wastage was co-signed, but it was unclear who co-signed with RN #127. Review of a document in the HR file indicated that the home management team spoke with RN #127 to verify the co-signer, but the RN stated they were unable to recall at the time. When RPN #110, the only nurse who worked on the same shift, was interviewed, they indicated that they did not co-sign for the narcotic waste. RPN #110 indicated that RN #127 dispensed the medication and co-signed by themselves. The document indicated that the home was unable to verify the co-signer and the reason why the medication was administered as there was no assessment completed. The document also indicated that the administration was not signed on the e-MAR. Inspector #645 reviewed the e-MAR and

the clinical notes, and the e-MAR was not signed. Inspector further reviewed the documents, and there were no detailed investigation, intervention to mitigate the issue and interviews available other than the summary note in the HR file.

- In June 2019, a note from the previous DOC, indicated a narcotic medication was administered to resident #012 by RN #127 and the wastage was not co-signed by a second nurse. The Inspector was unable to identify the dosage and time of administration as the HR note did not have detailed information. The notes from DOC indicated that RN #127 dispensed the medication. Further review of the note indicated that the RN was instructed not to administer medication to residents as medication administration was a duty of a medication nurse and not the nurse in-charge. The RN was also advised to get a second nurse to witness the waste and co-sign it with another nurse.

- Record review of the progress notes and the e-MAR for resident #031 indicated that RN #127 changed the resident's medications frequently. RN #127 had sporadic ordering and discontinuation of medications without any proper documentation and assessments to support the reasons for the frequent changes. The resident was receiving narcotic capsule by mouth in October 2016, and discontinued in November 2016. On the same day, a narcotic vial was ordered. There was no indication in the resident’s clinical notes regarding the ineffectiveness of the narcotic capsules prior to discontinuation.

- Record review of the progress notes and the e-MAR for resident #035 indicated that they were receiving oral narcotic capsules that was discontinued in January 2019. On the same day, another narcotic medication was ordered for the resident but the administration of the medication was not signed on the e-MAR. There was no indication in the resident’s clinical notes regarding the ineffectiveness of the narcotic capsules prior to discontinuation.

- Interview with RPN #110 indicated that they were aware of the ongoing issues regarding narcotic dispensing and administration concerns. RPN #110 indicated that RN #127 tended to get an order for narcotic medications frequently and administer it to residents. The RPN remembered two incidents where they were very suspicious of the RN, as the narcotic order did not make sense to them. The RPN was unable to recall the names of the residents but indicated that on both occasions, the residents did not need the medications. There were no assessments completed to justify the need for the medications. They remembered that they couldn’t justify the need for the narcotics at the time and called the physician to have them discontinued. The RPN indicated that the

best practice was to initiate non-pharmacological treatments and assess residents; if the medication doesn't work, then narcotics can be considered. The RPN indicated that RN #127 always has issues with signing and co-signing narcotic medications, and these errors had been happening more frequently than normal. It was very suspicious. The RPN indicated that the home management instructed them not to give the narcotics key to RN #127. The home management team was very suspicious as well, but no actions were taken. The RPN indicated that there was a time when they worked with RN #127 and they were the only nurse working on that shift. RN #127 dispensed/administered narcotics for two residents and they did not co-sign for the wastage. They indicated that the home management asked them if they co-signed on the document that day, but they indicated they didn't co-sign. The RPN recalled that those residents did not need the narcotic medications and they were not sure why it was given. The RPN further indicated that the RN used to empty the sharp containers where nurses dispose the wasted and unused narcotics. The RN had a practice of taking the sharp containers to the utility room or to the office in the nursing station for unknown reasons. The RPN indicated that removing sharp containers was a duty of the environmental staff members, and not the registered staff. The home management team put a locking system on the containers to prevent the RN from removing it. The RPN further indicated that they were always worried about their nursing licence and residents' safety whenever they worked with RN #127.

Interview with RN #132 indicated that RN #127 had ongoing issues with narcotic medications since 2016. RN #127 was known to give narcotics to residents that did not require it. They always had an issue with dispensing and administering the medication and co-signing the wastage with other staff members. The home management team knew about this a few years ago, but nothing was done about it. RN #132 indicated that they reported RN #127 to the home management team many times as they suspected resident neglect due to residents being given medications that they did not require. RN #132 also suspected narcotic diversion as RN #127 specifically focused on palliative residents to administer medication. They believed the RN was giving narcotics to gain access to the wastage. The RN indicated that RN #127 called the physician all the time seeking new orders for narcotic medications before trying other alternatives. There was a specific fascination about narcotic medications that would make anyone suspicious. The home management team instructed all nursing staff not to give the narcotic key to RN #127 even when going on break, as the RN tended to dispense and administer them to residents that don't need it. RN #132 stated that they never shared the narcotic key with them, and were always on high alert when the RN was on duty. RN #127 used to take the sharp containes and empty them, and when asked they always said they wanted to

help. Two years ago, a family member of resident #033 was upset that RN #127 administered narcotics to the resident without their consent, and had the medication stopped immediately. Similarly, a family member of resident #031 was upset as RN #127 called and told them that their loved one needed palliative care and comfort measures, but there was no consultation with the interdisciplinary team. RN #132 indicated that palliative care decisions are based on an interdisciplinary approach. The team will hold a care conference with nurses, physician, DOC, family members and other disciplines to discuss the benefit of palliation, and if family agreed, the physician would initiate palliative orders. In the above mentioned cases, the RN did not collaborate with the other members of the interdisciplinary team and obtained palliative orders. In 2017 and 2018, RN #127 was instructed not to give medications to residents as the home management was suspicious about narcotic diversion, but the RN continued to give medications regardless. RN #132 indicated that another RN from a different shift would save narcotic waste for them instead of wasting and co-signing it with another nurse on the same shift. RN #132 described RN #127's behaviour as strange; they arrived early to their shift or stayed late; they sometimes talked too much or was completely withdrawn. They were either extremely happy or cranky.

Interview with RN #104 indicated that they were always suspicious of RN #127 regarding narcotic dispensing and administration. RN #127 administered narcotics to residents frequently and put residents at risk. RN #104 indicated that RN #127 had a habit of getting a new orders for narcotics without completing the necessary assessments, then access the emergency drug box. On many occasions, the RN did not utilize the non-pharmacological methods or use non narcotic medications to manage residents' pain. They always had issues with signing on the e-MAR and getting someone to witness the wastage. They removed and emptied the sharp containers on the floor very frequently. They reported these concerns a few times and advised the home management team to get the appropriate authorities involved, and provide help for the RN. RN #104 described RN #127's behaviour as disengaged, and at times, extremely friendly.

Interview with RN #117 indicated that all staff members including RNs, RPNs and PSWs were aware of the suspicious behaviours of RN #127. The RN stated that one day in 2016, prior to going on their break, they gave the narcotics key to RN #127 after counting the narcotics. When they came back, they noticed one narcotic injectable vial was missing, and the narcotics sign out sheet was not signed. The RN indicated that they were nervous and asked RN #127 about the missing vial. RN #127 initially responded by saying they did not know anything about the missing vials, then later changed the story and stated that the narcotic vial fell on the floor and broke. RN #117 stated that they

couldn’t believe what they heard and started asking questions such as: why RN #127 opened the narcotic locker, if anyone witnessed the vial breaking, and who cleaned up the broken vials? RN #117 indicated that RN #127 responded angrily that the vials were broken, and no one witnessed it and then walked away. RN #117 indicated that they reported the incident to the management team as the RN lied initially and they were suspicious of narcotic diversion. They indicated, at the time, that there was no resident that required the narcotic medication and there was no reason to open the narcotic locking system. In addition, if the narcotic vial broke, the expectation was to get another registered staff to witness and waste it. In this case, there was no witness and no one co-signed. RN #117 indicated they remembered another incident approximately in the year of 2015/16 when RN #127 dispensed and administered a narcotic medication to resident #004, but the e-MAR was not signed and the narcotic sheet for the waste was not co-signed. They stated that they could not believe that no actions were taken despite many reports of residents’ neglect, and suspicious behaviours.

Interviews with PSW #133 and #134 indicated that they both observed suspicious behaviours and were aware about the ongoing narcotic issues with RN #127. PSW #133 indicated that they had observed RN #131 giving open medication vials to RN #127 on one occasion. The PSW indicated that one morning, they observed RN #127 reaching into their purse in the nursing office after RN #131 gave the medication vials to them. They were not sure if the RN placed the vials in their purse but they were very suspicious. The PSW indicated that RN #127 was very attentive to residents who were palliative or residents that were receiving narcotic medication. PSW #134 stated that on one occasion, while they were in the middle of providing care for a resident, RN #127 barged in the room. The RN seemed confused and nervous, then they quickly walked out of the room. A minute later, the RN returned to the room and told them to leave. PSW #134 stated that they were puzzled by the RN’s request and asked the reason. The RN responded by saying they have to use the resident’s bathroom. The PSW indicated that they left the room but was suspicious that the RN was up to something as the behaviour was strange. They indicated that no other staff member would use the residents’ washroom as there were staff washrooms available.

During the course of this inspection, record reviews and interviews, the inspectors were able to gather the following information. Multiple staff members indicated ongoing concerns regarding RN #127's narcotic dispensing, administration and diversions. The records indicated that these concerns were ongoing from the year of 2015 to 2020. Staff members alleged residents neglect, and reported to the home management team on more than one occasion. Multiple staff members signed a petition to express their

concern about RN #127 suspicious behaviours, and reported to the home management team. Staff members advised the home management team to notify the appropriate authorities and provide help to the RN. Review of residents' records indicated that multiple residents were administered narcotics by RN #127 without indication of pain or without proper pain assessments. Residents were given injectable narcotics when they could take oral medications. Review of the e-MAR record for multiple residents indicated that the administration of narcotics were not recorded or signed. There had been ongoing issues with signing and co-signing of narcotic wastage. There had been concerns from staff members that the RN #127 administered narcotics to residents when they didn't need it. Staff members alleged that the RN administered narcotics when they went on their break. Staff members reported multiple concerns regarding residents' safety and well-being. Staff members suspected narcotics diversion as the RN removed sharp containers from the medication carts on multiple occasions. Staff observed the RN self administering medication in residents' bathroom on two occasions. Review of records indicated that the MLTC and police were only notified in August 2020 after new management took over the home. The home had reasonable ground to suspect narcotic diversion and residents neglect since 2016 but failed to report to the MLTC and police in a timely manner. Review of the HR document indicated a few documentations and fact-finding summary notes. Inspector #645 was unable to locate written, signed and dated statements from staff members describing each allegation; there were no staff interviews available; and no investigation records for the incidents. The RN continued administering medications despite the fact they were instructed not to administer medications; medication errors and narcotic dispensing, and administration concerns continued; residents were given narcotic medications without proper assessment and the RN failed to use less invasive approaches; residents neglect and risk continued, and the home failed to protect the residents and implement the home's abuse policy. The RN continued exhibiting narcotic diversion behaviours that are outlined in the home's policy. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The home submitted a CIS report to the Director related to medication that was being administered to resident #031 that was not necessary. During the inspection, Inspector #698 also observed that there were missing signatures in the resident's e-MAR.

Review of the e-MAR indicated that resident #031 was receiving oral medications and narcotic injections for pain management.

Review of the resident's e-MAR in October and November 2016, indicated frequent changes and discontinuation of the resident's medication. Review of resident's Narcotic and Controlled Drug Administration Record indicated that multiple doses of narcotic medications were given, but the wastage was not signed. There were no assessments completed to indicate the need for frequent changes.

Review of the Professional Advisory Committee (PAC) binder for 2018-2020 by inspector

noted that there were no medication incidents related to narcotic medications.
Review of the home's policy titled, "Controlled Substances and Narcotic Count" policy # VIII-E-10.40 revised on May 2019, indicated that inventory counts of controlled substances/narcotics will be conducted between shifts, and an audit will be done monthly to maintain an accurate inventory and quickly and effectively identify missing medications or potential risks.

Review of Medical Pharmacies Policy and Procedure Manual for Long-Term Care policy #6-5 Definitions and Legal Requirements under procedure, indicated to document the administration of the monitored medication on the resident's e-MAR; sign on the "Individual Monitored Medication Record" each time a dose is administered by including the time, date, amount given, amount wasted, and new quantity remaining.

During an interview with DOC #119, they indicated that missing signatures on the e-MAR, Individual Monitored Medication Record and End of Shift Narcotic Sheets are considered to be a medication incident. Upon discovery, a medication incident report should be completed immediately and reported to the DOC. It is also addressed in the quarterly PAC meeting to identify root cause and analysis.

In summary, RN #127 did sporadic ordering and discontinuation of resident #031's medications without any proper documentation and assessments to support the reasons for medications being changed so frequently in the resident's plan of care. There was no indication in the resident's progress notes regarding the ineffectiveness of the non-narcotic medications prior to discontinuation, and no documentation to verify the need for strong narcotic medications. Resident was not properly assessed by the physician or nurse practitioner (NP), interdisciplinary team members or other external sources as specified in the home's policy. RN #127 did not follow the policy related to medication administration. RN #127 did not consult with above mentioned resources in the assessment of resident #031 so that their assessments were integrated and are consistent with and complemented each other.

b. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

The home submitted a CIS report related to medication that was being administered to resident #034 that was not necessary, and the resident was given narcotics for Palliative and End of Life Care.

Review of clinical records indicated that there were no documentation in resident #034's progress notes or care plan for palliative care status, nor was a care conference held with the resident's family and multidisciplinary team. Review of progress notes in September 2019, documented by RN #127 indicated changes in resident's health care status and meeting to be scheduled with the resident's daughter for the following week. Progress notes indicated that the resident was seen by the physician in October 2019 and that the interprofessional care team was not involved in the resident's End of Life Care.

Review of physician's orders in October 2019, indicated a telephone order was obtained by RN #127 for End of Life Care and to discontinue all oral medications. There was no documentation of any family meeting in the progress notes from September 2019 until the resident passed away the following month. RN #127 made this decision soley and did not consult with the interprofessional team and the SDM in deeming the resident palliative.

Review of the home's policy titled, "Palliative Care - Care of the Resident" policy # VII-G-30.40 revised on April 2019, indicated that an interprofessional care team approach will be provided within each care community to meet the physical, emotional, spiritual, and ethno-cultural needs of both the resident and their family; all Palliative residents should have comprehensive assessments and a current, up to date plan of care which will be completed using an interprofessional approach; wherever possible, an interdisciplinary conference will be held to ensure that all of the resident's needs are planned for and able to be met; while palliative care can be a component of end-of-life care, end-of-life care also includes aspects that are care planning beyond the scope of palliative care, such as advance care planning; whether palliative and/or end-of-life care, the care community will maintain a consistent delivery of care utilizing the interprofessional care team approach continuum to support residents and their loved ones. The nurse will complete required assessments triggered based on change in resident status i.e. pain, skin, continence; complete referral if required to Dietary, Therapies, OT, PT, ET Nurse, Spiritual Care Providers, etc; coordinate an interdisciplinary care conference with resident/POA to discuss changes in resident condition and advance care planning, and establish a plan of care to meet resident's needs; document in electronic chart and update plan of care.

During an interview with DOC #119 they indicated that registered staff are expected to inform the resident's SDM and the physician after they have done an assessment of the

resident before deeming them palliative. If the family requests for palliative care, the staff must inform the physician and a palliative conference is held with the family and the multidisciplinary team, with documentation of the resident's goals. A palliative scale must be done to determine the resident's health status.

In summary, the licensee failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other, and reflected in the plan of care. RN#127 did not consult with the interprofessional care team when resident #034 was placed on Palliative care. [s. 6. (4) (a)]

2. The licensee has failed to ensure that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of resident's #033 plan of care. 2007, c. 8, s. 6 (5).

The home submitted a CIS report related to medication that was being administered to resident #033 that was not necessary.

Resident #033 was given a narcotic medication in October 2018, without the consent of their SDM.

Review of the progress note in October 2018, by RN #127 stated that the SDM was informed of resident's condition, and that the resident was experiencing distress. The notes indicated that the narcotic medication was administered to promote resident's comfort and determined effective. However, a note from the SDM in October 2018, indicated that they wanted to discontinue the narcotic treatment and only to give non narcotic medications when needed.

Review of the Individual Monitored Medication Record Sheet, indicated that the narcotic medication was administered by RN #127 to resident #033 in October 2018. Review of the clinical notes under Orders Administration, indicated there was no documentation or signatures on the e-MAR.

Interview with RN #126 indicated that Orders are written in the physician's order section and the order goes directly to the pharmacy. It is expected to be typed directly into the e-MAR immediately by the nurse who obtains the order. The SDM must be notified when medication orders are changed, and everything must be documented in the progress notes.

In summary, the licensee failed to ensure that the resident's substitute decision-maker was given the opportunity to participate fully in the development and implementation of the resident #033's plan of care. [s. 6. (5)]

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 staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and (b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, and that the resident's substitute decision-maker was given an opportunity to participate fully in the development and implementation of the resident's plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident receives end-of-life care when required in a manner that meets their needs.

1. A CIS report was received by MLTC regarding the unexpected death of resident #001.

Review of the progress notes indicated that RPN #100 found the resident unresponsive with vital signs absent (VSA). The RPN called RN #101 and initiated Cardiopulmonary Resuscitation(CPR). Review of the home's investigation notes indicated that the RN and RPN stopped the resuscitation attempt when the resident was not responding to the CPR. The notes indicated that both staff members did not call 911 and failed to transfer

the resident to hospital. The RN and RPN stopped the CPR without further direction from the physician and pronounced the resident's death. During the home's investigation interview, the RN explained to the home that they knew the resident was a full-code status and they would normally call 911, conduct CPR until paramedics arrive, and notify MD. The RPN stated that they did not call 911 during the medical emergency because paramedics were "rude and useless" in previous visits. The home determined the action of the staff members was neglect as they withheld the necessary treatments required for the well being of the resident, and the resident's end of life wish was not respected. As a result, the home took disciplinary actions.

Interview with RPN #100 indicated that they did not call 911 as the resident was VSA. They did not believe calling 911 was useful. The RPN regretted the incident and indicated that the end of life care wishes/advance directives of the resident was full resuscitation and transfer to hospital. They admitted that they did not respect the resident's end of life care wishes.

Interview with the aED indicated that the resident's end of life care wishes was CPR with hospital transfer. They indicated the actions of both nurses were in violation of the residents bill of rights and end of life care wishes. [s. 42.]

2. A CIS report was received by MLTC regarding the unexpected death of resident #004.

Review of the resident #004's clinical records indicated that the resident passed away unexpectedly in January 2020. Review of the progress notes indicated that RPN #114 entered the resident room to administer medications and the resident was unwell. The notes indicated that the resident suddenly became unresponsive, had no pulse and RN #115 pronounced the death. Review of the resident's end of life wishes included transfer to hospital with no CPR. Review of the records did not indicate if the resident was transferred to hospital. Review of the home's investigation notes indicated that both the RPN and RN were disciplined for not respecting the resident's end of life wishes.

Interview with RPN #114 and RN #115 revealed that they did not attempt to transfer the resident to hospital on that day. The RN indicated that they reviewed the resident's chart and found a previous document from the year of 2017, that stated no CPR and no transfer to hospital. The RN indicated that they did not realize the resident's end of life care wishes were changed in 2018, which included transfer to hospital.

Interview with the interim aED indicated that the resident's end of life care wish was to be transferred to hospital and RPN #114 and RN #115 did not send the resident to hospital on January 2020. [s. 42.]

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 every resident receives end-of-life care when required in a manner that meets their needs, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that once a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

The home submitted a CIS report related to medication that was being administered to resident #034 that was not necessary. During the inspection, Inspector #698 noted that there were no assessments, monitoring or documentation of the effectiveness of the

drugs being administered to the resident.

Review of resident #034's e-MAR indicated that in April 2019, the resident was prescribed an oral antidepressant and was discontinued in October 2019. Further review of the e-MAR indicated the following medications:

An Antipsychotic medication was ordered on August 2019, and discontinued in October 2019.
A narcotic medication to manage pain was ordered on May 2019, and discontinued in August 2019.
A non narcotic medication for pain management was ordered in April 2019, and discontinued in October 2019.

Review of resident #034’s e-MAR indicated that they were prescribed a combination of drugs, including psychotropic, analgesics and narcotics drugs. Review of progress notes indicated that there were no pre or post pain assessment done each time resident #034’s pain medication orders were changed, to indicate that previously ordered medications were ineffective. There were no monitoring and documentation of the resident’s response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Review of the home’s policy titled, “Pain and Symptom Management” policy #VII-G-30-30, indicated that the nurse will screen for presence of pain and complete a pain assessment electronically; monitor and evaluate effectiveness of pain medications in relieving resident’s pain using pain scale in the vitals section of the electronic documentation system; include interventions related to pain assessment and symptom management in the plan of care with 24 hours of move in and update as necessary; make referral to appropriate interprofessional team members as necessary; consider initiating Pain Study Tool for 24 hours or longer to assist with the assessment; evaluate plan of care for effectiveness and revise as needed.

During an interview with DOC #119, they indicated that pain assessment was required to be done pre/post analgesic medication administration; that according to Best Practice Guidelines (BPG), when implementing interventions for behaviours, the least invasive approach should be considered first. A non-pharmacological approach followed by oral medication should be considered before injections.

In summary, the home did not ensure that there was monitoring and documentation of the resident’s response and the effectiveness of the drugs, appropriate to the risk level of

the drugs when resident #034 was prescribed a combination of drugs, including psychotropic, analgesics and narcotics drugs. There was insufficient monitoring, assessments, documentation of the effectiveness and resident's responses to medications that were ordered. There was no documentation of notifying the residents SDM each time orders were being changed. RN #127 did not consult with the home's internal multidisciplinary team and external resources for pain management when they obtained multiple medication orders. [s. 134. (a)]

2. The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

The home submitted a CIS report related to medication that was being administered to resident #034 that was not necessary. During the inspection, Inspector #698 noted that there were missing signatures in the resident's plan of care.

Record review of the shift count for resident #034 indicated that narcotics prescribed for the resident were not signed off on the Individual Monitored Medication Record. The e-MAR indicated that two narcotic medications were administered in October 2020 by RN #109. Neither of these medications administered at the above stated times were signed off on the e-MAR, and there was no witness for the wastage.

Review of the e-MAR on the above-mentioned dates did not show that the medication was administered to resident #034.
Review of the home's Professional Advisory Committee (PAC) binder by inspector indicated that the last PAC meeting was held in January 2020. Review of the home's 2019 Medication Incident Binder, revealed that there were no medication incident reports addressing any concerns regarding Narcotic discrepancies and e-MAR signatures.

During an interview with DOC #119, they indicated that all medication incidents and adverse drug reactions are documented, reviewed and analyzed quarterly in order to reduce and prevent medication incidents and adverse drug reactions. The report goes to pharmacy and they do their investigation and the home investigates and provides education. Corrective action is taken as necessary, related to the results of the review and analysis of medication incidents. PAC meetings are held quarterly to review these concerns in order to reduce or prevent recurrence. The home also keeps a written record of everything, including the review.

In summary, the home did not ensure that medication prescribed for resident #034 was documented appropriately. RN #109 and RPN #111 did not document on the resident's electronic record the medication being administered. An incident report was not completed to capture the incidents that occurred relating to medication administration for resident #034. [s. 134. (b)]

3. The licensee has failed to ensure that appropriate actions were taken in response to any medication incident involving a resident.

The home submitted CIS report related to medication that was being administered to resident #033 that was not necessary.

Review of progress notes indicated that RN #127 informed resident #33's daughter of the resident's condition in October 2018, that the resident was experiencing distress. However, a note from the resident's daughter indicated that they wanted to discontinue the narcotic medications and only to give medications to promote breathing. Review of the progress notes in October 2020 indicated that the narcotic was administered to promote resident's comfort and determined to be effective. Further review of the notes did not indicate if a pre/post pain assessment was completed.

Review of the Medical Pharmacies Individual Monitored Medication Record Sheet, indicated that the narcotic was dispensed and was administered by RN #127 to resident #033 in October 2018, but there were no documentation and no signatures on e-MAR for the administration.

Review of the home's policy titled, "Controlled Substances and Narcotic Count" policy # VIII-E-10.40, last revised on May 2019, indicated that inventory counts of controlled substances/narcotics will be conducted between shifts, and an audit will be done monthly to maintain an accurate inventory and quickly and effectively identify missing medications or potential risks.

Review of Medical Pharmacies Policy and Procedure Manual for Long-Term Care policy #6-5 Definitions and Legal Requirements under procedure indicated to document for the administration of the monitored medication on the resident's e-MAR; sign on the Individual Monitored Medication Record, each time a dose is administered by including the time, date, amount given, amount wasted, and new quantity remaining.

Interview with RN #126 indicated that Stat Orders are written in the physician's orders

and the order goes directly to the pharmacy. It is typed directly into the e-MAR immediately on the same day by the nurse who obtains the order. The family is notified when medication orders are changed, and everything is documented in the progress notes. If Stat orders are not entered by pharmacy, the nurse should manually put them into the e-MAR, sign off on any medications administered and notify the pharmacy when it is done.

During an interview with DOC #119, they indicated that missing signatures and information on e-MAR, Individual Monitored Medication Record and End of Shift Narcotic Sheet are considered to be a medication incident. They continued to say that upon discovery, a medication incident should be completed immediately and reported to the DOC. It is also addressed in the quarterly PAC meeting to identify root cause and analysis.

In summary, the licensee failed to ensure that appropriate actions were taken in response to a medication incident involving resident #033. [s. 134. (b)]

4. The licensee has failed to ensure that appropriate actions are taken in response to any medication incident involving resident #035.

The home submitted a CIS report related to medication that was being administered to resident #035 that was not necessary. During the inspection, Inspector #689 noted that there were missing signatures in the resident’s e-MAR.

Review of resident #035’s physician’s orders and e-MAR by Inspector #698 indicated that a narcotic medication was administered to resident #035 in March 2018, and discontinued by RN #127 in January 2019. A non-narcotic medication for pain management was ordered in August 2017. A narcotic injection was ordered in January 2019, and was discontinued in February 2019. Review of the e-MAR indicated that the medication was not transcribed or administered to the resident and was signed off, as dispensed, on the Individual Monitored Medication record by RN #127.

Review of resident #035's e-MAR in March 2019 indicated that another narcotic was ordered and administered to the resident to manage pain without any documented indication of pain from the resident, and there was no pre or post assessment completed to indicate effectiveness after medication administration.

Interview with RN # 126 indicated that Stat Orders are written in the physician’s orders

and the order goes directly to the pharmacy. It is typed directly into the e-MAR immediately on the same day. The family is notified when medication orders are changed, and everything is documented in the progress notes. If Stat orders are not entered by pharmacy, the nurse should manually put them into the e-MAR, sign off on any medications administered and notify the pharmacy when it is done. They continued to state that pain assessments should be completed before and after medication administration, and documented in the clinical notes indicating whether the drug was effective or not.

In summary, resident #035 was receiving oral narcotic medications for pain that was discontinued in January 2019. Another narcotic was ordered on the same day for the resident but was not signed for on the resident's e-MAR. There was no documentation of pain assessment pre or post medication administration.
Missing signatures were noted on the e-MAR, undocumented care in the progress notes and narcotic records were also missing.

The licensee failed to ensure that appropriate actions were taken in response to medication incidents involving resident #035 when documentation on the e-MAR, Narcotic records and progress notes were not properly done for narcotic administration according to the home's policy. RN #127 also did not properly assess resident #035's pain level each time their medication was being discontinued and ordered. [s. 134. (b)]

5. The licensee has failed to ensure that appropriate actions were taken in response to medication incidents involving resident #036.

The home submitted a CIS report related to medication that was being administered to resident #036 that was not necessary. During the inspection, Inspector #698 also noted that there were missing signatures in the resident's plan of care.

Review of the e-MAR indicated that an antipsychotic medication was ordered in August 2019, and discontinued in October 2019; a narcotic medication to manage pain was ordered in May 2019, and discontinued in August 2019; a non-narcotic medication for pain management was ordered in April 2019, and discontinued in October 2019. Review of the e-MAR indicated that the narcotic medication was not transcribed and there was no signature to verify administration.

During an interview with DOC #119, they indicated that missing signatures and information on the e-MAR, Individual Monitored Medication Record and End of Shift

Narcotic Sheet are considered to be a medication incident. They continued to say that upon discovery, a medication incident should be completed immediately and reported to the DOC, and that it is also addressed in the quarterly PAC meeting to identify root cause and analysis.

In summary, the licensee failed to ensure that appropriate actions were taken in response to medication incidents involving resident #036. [s. 134. (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, (a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs; (b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and (c) there is, at least quarterly, a documented reassessment of each resident's drug regime, to be implemented voluntarily.

WN #5: 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 policy and procedure the home had,

instituted or otherwise put in place was complied with.

The home's policy titled "Resident Incident Management, #XXIII-D-10.00" last reviewed on June 2019, provided direction to staff members on how to deal with incidents. The policy directed staff members to do the following:
- to complete incident reports whenever a resident is involved in a harmful or potentially harmful incident.
- Complete an environmental scan and provide a thorough description of the incident
- Notify MD and SDM
- Complete appropriate assessment, and ensure ongoing monitoring and evaluation is completed.
- Investigate the incident, complete a root cause analysis and determine the antecedent causes, document investigation outcomes and update the plan of care.

A complaint was submitted to the MLTC regarding an alleged incident of abuse and neglect for resident #006. Interview with the complainant indicated that the resident had altered skin condition on their body part in February 2020. The complainant indicated that when they visited the resident in February 2020, they were advised that the resident fell and sustained the above-mentioned injuries.

Review of the home records did not indicate if the incident was investigated. There was no root cause analysis done, staff members were not interviewed and assessments were not completed to determine the antecedent cause of the injury.

Inspector #645 reviewed two additional fall incidents of resident #003 and #009 that had caused injury to the residents, to increase the resident sample due to identified non-compliance. Review of these two incidents indicated that the home completed initial assessments, root cause analysis to determine antecedent causes, determined the cause of injury and updated the plan of care for both residents. No concerns were identified within the increased sample size.

Interview with the ADOC #105, indicated that they do not recall if staff interviews were completed and there was no record available indicating if the incident investigation for resident #006 was completed. The ADOC indicated that they normally investigate every harmful or potentially harmful incident thoroughly and update the residents' plan of care to prevent recurrences.

2. Review of the home’s policy titled, “Controlled Substances and Narcotic Count” policy

VIII-E-10.40 revised in May 2019, indicated that inventory counts of controlled substances/narcotics will be conducted between shifts, and an audit will be done monthly/annually to maintain an accurate inventory, and quickly and effectively identify missing medications or potential risks. The policy directed the home to take immediate action when discrepancy is discovered. The home's policy, "Medication Storage and Security, policy # VIII-E-10.10" revised in May 2020, directed the home to store narcotic medication in accordance with the provincial and regulatory requirements, and to investigate when drugs are missing and notify the appropriate authorities.

Review of the Narcotic Drugs Audit monthly/Annual Tracking tool indicated the following:

- In May 2020, the monthly audit records indicated that narcotic discrepancies were identified. The records did not indicate if investigations were completed. Inspector #645 was unable to identify the date, type and dosage of the medication missing.

- The records indicated that there were no monthly audits completed from January to June 2019. The records also indicated another narcotic discrepancy was identified in December 2019. The DOC was notified but there was no investigation completed.

- The monthly audits for March, June, August, September, October, November, and December, 2018, were not completed.

- On another floor, the monthly narcotic audits were not completed for the months of February, April, May, June, July, August, September, October, November, and December, 2019 and

- In December 2016, the records indicated that a narcotic discrepancy was identified. The records indicated that the DOC was notified but did not indicate if an investigation was completed. Inspector #645 was unable to identify the date, type and dosage of the medication missing.

Interview with ADOC #105, indicated that they were responsible for conducting the monthly audits in the home. The ADOC indicated that they were not sure how they missed completing the above-mentioned audits and that they did not recall doing investigations for the missing narcotics. They indicated that it was the expectation of the home to complete the audits monthly and annually as per their policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #021 was not neglected by the licensee or staff.

In accordance with the definition identified in section 2(1) of the Regulation 79/10 “neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

A CIS report was submitted to the MLTC related to the unexpected death of a resident.

According to the CIS report, resident #021 was not deemed to be palliative and was tested for Coronavirus (COVID-19) in April 2020. The evidence in this report identified a lack of documentation in terms of what action was taken regarding the resident’s status, and further indicated that no contact was made with the physician until the resident’s death.

Record review indicated that the resident passed away in April 2020.

According to the clinical note, resident #021 was tested for COVID-19, and confirmed positive in April 2020. The resident’s SDM was informed of the results, and that there were no concerns. Further review indicated there was no documentation that the resident’s SDM was notified or kept updated on the resident’s status related to COVID-19.

Record review indicated that resident #021 was screened twice daily for COVID-19. The record indicated that the resident had symptoms of COVID-19 on multiple occasions in

April 2020. The e-MAR record indicated that the resident was given treatments to manage symptoms of COVID-19. Review of the physician's order indicated that if the symptoms persists for longer than 18 hours, to call the physician. There was no documentation to indicate that the physician was informed of same when the symptoms persisted over 18 hours.

In separate interviews, RNs #107 and #109 confirmed that resident #021 had been neglected. The resident did not receive the required treatments in April 2020, when they exhibited the symptoms; the physician was not informed when the symptoms persisted for more than 18 hours in April 2020; and the resident's SDM had not been updated when the resident's condition worsened.

In an interview with interim DOC #119, they acknowledged that resident #021 had been neglected. They explained that the physician or nurse practitioner (NP) should have been informed of the resident's abnormal findings and their SDM should have been kept updated throughout the process.

In an interview with interim aED #102, they acknowledged that neglect had occurred with this resident. They expected staff to call the physician, closely monitor the resident when they became positive for COVID-19, stated that an infection note was not consistently done every shift, and the resident's family was not notified of the changes. [s. 19. (1)]

2. The licensee has failed to ensure that resident #022 was not neglected by the licensee or staff.

A CIS report was submitted to the MLTC related to an allegation of improper treatment of resident #022.

A review of resident #022's clinical record indicated in April 2020, they were placed on isolation for potential exposure with COVID-19 from a co-resident post-hospitalization.

According to the clinical note, there was no further documentation of the resident's progress or health condition until they become very ill in April 2020. The notes indicated that the resident was added to the home's line list, had poor fluid intake and shortness of breath (SOB). RPN #113 noted the symptoms, and documented that they would endorse monitoring of the resident to the next shift. There was no documentation of any action taken by RPN #113 regarding the SOB.

RPN #124 received report from RPN #113 and worked the night shift. Similarly, review of resident #022's health record did not indicate any documentation of action taken by RPN #124 with regards to the SOB.

In April 2020, the resident passed away.

In an interview with RPN #113, they confirmed that neglect had occurred with resident #022. They further explained that the resident's condition was reported to them very late and therefore they were unable to take any action.

In an interview with RPN #124, they told the inspector that unfortunately they did not document in the progress notes, and had no concrete proof of the action they took with regards to the resident's SOB in April 2020. They stated that they had assessed the resident twice on their shift and had provided the required treatment. They told the inspector that they felt they did their due diligence, and did not feel they had neglected the resident.

In separate interviews with ADOC #121 and interim DOC #119, they both acknowledged that resident #022 had been neglected. The interim DOC explained that because the resident was line listed, staff should have been more conscious of this, and monitor the resident for signs and symptoms of infection. They stated a respiratory assessment should have been completed.

In an interview with the aED, they indicated that the resident should have had a chest assessment including oxygen saturation, and vital signs when there was documentation of SOB. They acknowledged that resident #022 was neglected.

The above failure of action demonstrated that resident #022 was neglected. [s. 19. (1)]

3. The licensee has failed to ensure that resident #001 was not neglected by staff.

A CIS report was received by MLTC regarding the unexpected death of resident #001. The report indicated that RPN #100 and RN #101, failed to call paramedics and stopped the CPR when the resident's vital signs were absent (VSA).

Review of the medical records indicated that the resident's code status was "CPR with hospital transfers" where all resuscitative and aggressive curative treatments were to be provided during medical emergencies, including but not limited to calling 911 for hospital

transfer, conducting CPR until paramedics arrive and take over, transfer the resident to hospital, and notifying the physician and family members.

Review of resident #001's clinical notes in June 2020, indicated that RPN #100 found the resident unresponsive and VSA. The RPN called RN #101 and initiated CPR. Review of the home's investigation notes indicated that the RN/RPN stopped the resuscitation attempt when the resident was not responding to CPR. The notes indicated that both staff members did not call 911 and failed to transfer the resident to hospital. The RN/RPN stopped the CPR without further direction from the physician and pronounced the resident's death. During the home's investigation interview, the RN explained to the home that they knew the resident was a full-code status and they normally call 911, conduct CPR until paramedics arrive, and notify MD. The RPN stated that they did not call 911 during the medical emergency because paramedics were "rude and useless" in previous visits. The home determined the action of the staff members was neglect as they withheld the necessary treatments required for the well being of the resident, and the resident's end of life wish was not respected. As a result, the home took disciplinary actions on both registered staff members.

Interview with RPN #100 indicated that they did not call 911 as the resident was VSA. They did not believe calling 911 was useful. The RPN indicated the incident was a huge learning opportunity and that they were saddened by the incident. The RPN indicated that the home provided them with training on prevention of abuse and neglect, CPR, resident bill of rights and code of ethics. The RPN stated that they would normally call 911 in medical emergencies, but they were not sure why they hesitated to call on that day.

Interview with the aED indicated that the action of the nurses was in violation of the home 's zero tolerance of abuse and neglect policy. They indicated that it was the expectation of the home and the College of Nurses of Ontario to call 911, complete CPR and transfer residents to hospital during medical emergencies. Since the resident's code status was "CPR with hospital transfer" registered staff are expected to conduct CPR and transfer the resident to hospital unless directed otherwise by the family or the physician. In this case, the RN/RPN neglected the resident's wishes by stopping the CPR, and not calling 911 during the medical emergency. [s. 19. (1)]

4. The licensee has failed to ensure that resident #002 was not neglected by staff.

A CIS report was received by MLTC regarding improper/incompetent treatment and

neglect of resident #002. The report indicated that RPN #108 failed to call the physician and transfer the resident to hospital when the resident's health condition deteriorated in April 2020.

Review of the clinical records indicated that resident #002 tested positive for COVID-19 in April 2020. The records indicated that there were no respiratory or physiological assessments completed until the end of April, 2020. There was no documentation available describing the health status of the resident after they were confirmed COVID-19 positive. The clinical records indicated that the resident had symptoms of COVID-19 on multiple occasions and required treatments. Review of the physician order in March 2020, directed staff members to notify the physician if the symptoms persist over 18 hours.

The records indicated that the resident had symptoms for more than three days (72 hours) and the physician was not contacted. The progress notes indicated that resident #002 was lethargic, had decreased level of consciousness (LOC), decreased fluid/food intakes and was only responding to loud verbal stimuli. The vital signs record indicated the resident was unstable. RPN #108 documented the resident's condition in the home's 24hr communication binder and a note was left for the Nurse Practitioner(NP) to assess the resident the next day. The records indicated that the resident was not transferred to hospital immediately and the MD or NP was not contacted immediately. The next day, the NP assessed the resident, immediately notified the SDM and transferred the resident to hospital where they later died on the same day.

Interview with the aED indicated that it was the expectation of the home that registered staff notify the MD when residents' condition changes and transfer them to hospital, unless specified otherwise. They indicated that resident #002's end of life wish was CPR with transfer to hospital, and they expected staff members to transfer the resident to hospital when their health condition declined on April 2020. [s. 19. (1)]

5. The licensee has failed to ensure that resident #003 was not neglected by staff.

A CIS report was received by MLTC regarding the unexpected death and improper/incompetent treatment and neglect of resident #003. The report indicated that the resident had a fall and died on the same day in July 2020.

Review of the post fall assessment indicated that the resident sustained an injury to an identified part of their body and required the use of a specific type of assessment tool to

monitor them frequently. Review of the assessment tool indicated that the resident was not monitored as specified, was found unresponsive a few hours later and died on the same day.

Review of the home’s investigation notes indicated that RPN #122 and #123 were suspended for not assessing the resident and completing the assessment tool. The home determined the action of the nurses as incompetent treatment and neglect of resident #003.

Review of the progress notes indicated that the physician was unhappy with the fact that they were not notified about the resident's injury. The physician documented that the home did not contact them or the on-call physician. The physician indicated that they would have sent the resident to hospital for further assessment, if they were notified.

Interviews with RPNs #122 and #123 indicated that they were suspended then returned to work after they completed training on prevention of abuse and neglect. Both nurses indicated that the incident was a big learning opportunity and regretted their inaction to properly care for the resident.

Interview with the aED indicated that it was the expectation of the home that registered staff notify the MD when residents’ condition changes and complete the necessary assessments. They indicated that RPN #112 and #123 violated the home’s zero tolerance of abuse and neglect policy and was disciplined for not providing appropriate care for resident #003. [s. 19. (1)]

6. The licensee has failed to ensure that resident #007 was not neglected by staff.

Resident #007 was confirmed COVID-19 positive in April 2020. The progress notes indicated that the resident had signs and symptoms of COVID-19 and treatment was provided initially. Resident's #007's clinical records indicated that the resident's condition deteriorated in late April 2020 but there was no assessment completed by the physician or the NP until May 2020. There were no assessment, and documentation regarding disease prognosis until the resident was unresponsive and had unstable vital signs.

Further review of the records did not indicate if the physician or NP was contacted.

Interview with the aED indicated that it was the expectation of the home that registered staff notify the physician when residents’ condition changes and complete the necessary

assessments. [s. 19. (1)]

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that was reported was immediately investigated, such as abuse of a resident by anyone, neglect of a resident by the licensee or staff, or anything else provided for in the regulations.

A complaint report was received by the MLTC in August 2020 regarding an alleged incident of abuse and neglect of resident #006 that occurred in February 2020. Interview with the complainant indicated that in February 2020, the resident had a massive injury on their body part. The complainant indicated that they submitted a written complaint to the home in February 2020.

Record review of the written complaint letter submitted to the home indicated that the family alleged resident #006 was physically abused by staff members and sustained the injuries. Further review of the home's records did not indicate if the allegation of abuse was investigated.There were no records of staff interviews available.

Interview with the aED confirmed that the home did not investigate the allegation of abuse and there was no documentation available. [s. 23. (1) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that an alleged incident of abuse of a resident, by the licensee or staff, was immediately reported to the Director.

A complaint report was received by the MLTC in August 2020 regarding an alleged incident of abuse and neglect of resident #006 that occurred in February 2020. Interview with the complainant indicated that in February 2020, the resident had a massive injury on their body part. The complainant indicated that they submitted a written complaint to the home in February 2020.

Record review of the written complaint letter submitted to the home indicated that the family alleged resident #006 was physically abused by staff members and sustained injuries. Further review of the records did not indicate if the MLTC was notified about the alleged incident of abuse.
Review of a written conversation between the previous DOC and the complainant in March 2020, indicated that the DOC was aware of the alleged incident. Inspector #645 reviewed the Long-Term Care Homes.net reporting website and was unable to locate a mandatory critical incident report submitted by the home, regarding the alleged incident of abuse in February 2020.

Interviews with the Interim aED and current-DOC confirmed that the home received the complaint letter about the alleged incident of abuse in February 2020, but it was not reported to the MLTC until August 2020. [s. 24. (1)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was developed for resident #006 related to their altered skin conditions.

Review of a complaint report indicated that resident #006 had an altered skin condition in February 2020. Review of a photo of the resident from February 2020, indicated that the resident had a massive injuries on the identified part of their body.

Review of resident #006's plan of care with full revision did not indicate a focus related to the altered skin conditions following the skin injuries in February 2020. Further review of progress notes did not indicate if an interdisciplinary discussion was conducted regarding skin and wound management.

Interview with ADOC #121, who is also the home's wound care lead, indicated that when a resident has altered skin conditions, they would expect the registered staff to develop interventions to monitor the wound prognosis, signs of infections, and update the plan of care. The ADOC confirmed that the plan of care effective at that time did not indicate a focus related to the resident's altered skin conditions. [s. 26. (3) 15.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any action taken with respect to a resident under a program, including assessments, reassessments, interventions and resident #023's responses to the interventions were documented.

A CIS report was submitted to the MLTC related to an allegation of improper treatment of a resident.

Record review of the progress note indicated that resident #023 was screened twice daily for COVID-19, and had symptoms of COVID-19 and required treatments. The notes indicated that the resident had recurring symptoms of COVID-19 despite receiving the treatments, and the treatment was not provided on all the occasions. Further review indicated that the effectiveness of the treatments were not assessed and documented. According to the resident's clinical records, there was no documentation to indicate that the physician or NP had been informed of the resident's recurring symptoms. Review of the physician order directed staff that if the resident's symptoms persists for more than 18 hours to contact the physician. There was no documentation that this medication was administered when the resident exhibited the symptoms on all occasions, or that the physician was contacted when the resident's symptoms exceeded 18 hours.

In an interview with RPN #118, who worked with the resident in April 2020, they confirmed that the physician or NP had not been informed about the resident's symptoms, and acknowledged that they should have been made aware.

In an interview with RPN #110, who worked with the resident in April 2020, they acknowledged that they had not completed a follow-up assessment to determine the effectiveness of the treatments when the symptoms persisted after they administered the medication. They also confirmed that they had not informed the physician or NP.

In an interview with interim DOC #119, they acknowledged that staff were not reassessing the resident.

In an interview with the interim ED #102 who submitted the CIS report, they told the inspector that they expected staff to administer the required treatments and document their assessment of the effectiveness. They further explained that they should have contacted the physician when the resident's symptoms persisted. [s. 30. (2)]

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. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees.

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:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the unexpected death of resident #004, was immediately reported to the MLTC.

A CIS report was received by the MLTC regarding the unexpected death of resident #004.

Review of the records indicated that resident #004 passed away unexpectedly in January 2020, but the MLTC was notified five months. Review of the progress notes indicated that RPN #114 entered the resident room to administer medications and found the resident unwell. The notes indicated that the resident suddenly became unresponsive and had no pulse. Review of the CIS reporting system did not indicate that the unexpected death was reported to the MLTC.

Interview with the aED indicated that the incident occurred during the home's previous management and they were not sure why the incident was not reported to the Director immediately. The aED further indicated that the death of resident #004 was unexpected and it was the expectation of the home to report the incident to the Director immediately. [s. 107. (1) 1.]

WN #12: 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 resident #021 in accordance with the directions for use specified by the prescriber.

A CIS report was submitted to the MLTC related to the unexpected death of resident #021.

Record review indicated that resident #021 passed away in April 2020.

Record review indicated that resident #021 had recurring symptoms of COVID-19 and required treatments. Review of the e-MAR, indicated that the resident was not given the necessary treatment on all the occasions. The physician order also directed staff to contact the physician if the symptoms persisted for more than 18 hours; there was no documentation that this action was completed. Therefore, the physician’s order was not followed as directed.

In separate interviews with RN #107 and #109, they both acknowledged that the physician’s order had not been followed.

The physician was contacted but refused an interview with Inspector #649.

In an interview with aED, they explained that staff members are expected to follow the physician’s order. [s. 131. (2)]

2. Review of the CIS report indicated that residents #002 and #006 tested positive for COVID-19 in April 2020. Record review of the physician order for both residents indicated that treatments were ordered and direction was given to call the physician if symptoms persists longer than 18 hours.

Record review of the progress notes indicated that the residents exhibited symptoms for more than 18 hours, and the physician was not contacted as specified by the prescriber.

Interview with charge nurse #116 indicated that the physician order directed staff members to contact the physician if symtoms persisted over 18 hours. They indicated that it was the expectation of the home and the College of Nurses of Ontario (CNO) to administer medications and follow the prescriber’s orders at all times. [s. 131. (2)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The home's policy titled "Novel Coronavirus-COVID-19 Infection Prevention and Management, IX-N-10.40" under the home's infection Prevention & Control program, effective in April 2020, directed staff members to do the following but not limited to:
1- Conduct active screening of residents and staff members
2- Document twice daily the findings of screening in the electronic health records
3- Initiate the checklist for probable and confirmed COVID-19 cases. The checklist included IPAC interventions, COVID assessments and documentation guides for confirmed COVID cases and
4- Conduct further clinical assessments for COVID-19 positive residents and document daily using the Resident Daily Status Assessment tool until COVID -19 is resolved.

Review of the progress note indicated that resident #002 was confirmed COVID-19 positive in April 2020. Further review of the records did not indicate if the resident was assessed until they were medically unstable. The records did not indicate if the above mentioned assessments were completed. There were no records of the daily status assessment documentation. There was no documentation available to review the resident's health condition.

Interview with RN #104 confirmed that there was no daily status update completed for the resident after they were confirmed positive for COVID-19. The nurse indicated that staff completed vital signs, but there were no respiratory or neuro assessments completed to assess the resident's health condition.

Interview with the aED confirmed that it was the expectation of the home that staff complete assessments every shift once a rsident is confirmed COVID-19 positive. In this case, the registered staff did not assess or complete the shift and daily status update tool. The aED confirmed that staff members did not participate in the implementation of the infection prevention and control program of the home. [s. 229. (4)]

2. Review of the progress note indicated that resident #006 was confirmed COVID-19 positive in April 2020. There were no records of the daily status assessment documentation from April to May 2020.There was no documentation available to review the resident's health condition during the above-mentioned dates.

Interview with ADOC #105 confirmed that there was no daily status update completed for the resident after they were confirmed positive for COVID-19 on April 2020. The ADOC indicated that it was the expectation of the home that staff complete the assessment of residents once confirmed COVID-19 positive. In this case, the registered staff did not assess or complete the daily status update tool. [s. 229. (5)]

Issued on this 26th day of January, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEREGE GEDA (645), JULIEANN HING (649), ORALDEEN BROWN (698)
Inspection No. / No de l'inspection :	2020_526645_0006
Log No. / No de registre :	012507-20, 012635-20, 012645-20, 012673-20, 012681-20, 012685-20, 012690-20, 012899-20, 013994-20, 014693-20, 016186-20, 017037-20
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 21, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Camilla Care Community 2250 Hurontario Street, Mississauga, ON, L5B-1M8
	Tracy Richardson

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 Administrator / Nom de l’administratrice ou de l’administrateur :

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Order # / No d'ordre : 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. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

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

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

The licensee must be compliant with s. 20 (1) of the Long-Term Care Homes Act.
Specifically the licensee must:

1. Ensure that residents are protected from abuse by RN #127 and all other staff.
2. Ensure that all alleged incidents of abuse, and suspected narcotic diversions are fully investigated, and the appropriate authorities are notified in a timely manner.
3. Ensure that narcotic medications administered to residents are documented in the electronic medical record (e-MAR), and the necessary assessments are completed to determine effectiveness.
4. Ensure that all narcotic medication wastage are witnessed by a second registered staff, and the wastage is documented.
5. Ensure that medication incidents, and missing narcotics or discrepancies, are fully investigated, and a quarterly medication review is completed; ensure all investigative documents and records are kept in the home.
6. Ensure that the necessary pre/post pain assessments are completed before and after administering analgesic and other narcotic medications.
7. Ensure that palliative care decisions are made with an interdisciplinary approach, and family members are involved in the development of the plan of care.
8. Create an auditing system to identify unwarranted and frequent use of narcotic medications.
9. Ensure staff are trained/re-trained on the home‘s pain management program, safe medication administration, and the policy and procedure of narcotic dispensing and wastage processes.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's Prevention of Abuse and Neglect of a Resident policy, # VII-G-10.00, Current Revision: April 2019, was reviewed, and indicated the following:
All team members are required to report immediately any suspected or known incident of abuse or neglect to the provincial health authorities and the Executive

Director or designate in charge of the care community;
- the Executive Director or designate, at the time of immediate notification, initiates the investigation by requesting that anyone aware of or involved in the situation write, sign, and date a statement accurately describing the event, reiterating anonymity and protection against retaliation.
- the alleged neglect/abuser is also asked to write, sign, and date a statement of the event
- the written statements are obtained as close to the time of the event as possible; and
- the Executive Director or designate interviews the resident, other residents, staff members and/or persons who may have any knowledge of the situation.
- Immediately notify the Ministry and/or the Police of any alleged, suspected, or witnessed incident of abuse or neglect of a resident which may constitute a criminal offence.
- the Executive Director or designate interviews those persons completing the statements after the statement has been written.
- all investigative information is kept in a separate report from the resident's record.

The home's Abuse policy defined physical abuse as : a)The use of physical force by anyone, other than a resident, that causes pain or may cause pain, b) Over-medication, withholding medication, or medicating of a resident when it is not medically necessary to do so and c) Any undue physical force by team members when providing care to a resident.

The home's policy titled Detecting Signs of Diversion, Policy #VII-E-10-10(a) last revised May 2019, described signs of narcotic diversion but not limited to the following:
- Evidence of frequent tampering and substitution of narcotics
- Frequent disappearances to bathroom or dirty utility room for prolonged periods
- Unusual wasting medication pattern
- Progressively poor charting and residents' assessments
- Declining interpersonal relationships
- Arriving early to work and staying late after shift
- High achievers
- Unusual wasting medication pattern

- Frequent breaking of ampules and discrepancies and
- Narcotics waste not signed.

A Critical Incident System (CIS) report was submitted to the Ministry of Long Term Care (MLTC) regarding an alleged incident of abuse and neglect involving eighteen (18) residents. These residents were given narcotic medications by RN #127 when they didn't need it. There were multiple allegations of narcotic diversion by the same staff member and the allegations were ongoing since 2016. In 2016, PSW #128 witnessed RN #127 self injecting/administering narcotic medications that were prescribed for residents in a resident's washroom, and brought the concerns to the home management team. The PSW reported the incident again to the new management team in August 2020, as these concerns were still ongoing, and believed no actions were taken to protect residents after they reported the allegation in 2016. RN #127 is still employed at the home and was providing care until May 2020. Review of the records indicated that the MLTC and the police were not notified regarding the allegation of abuse and narcotic diversion until August 2020.

Review of the Human Resource (HR) file for RN #127 indicated that the previous management team was aware of the allegations in 2016 and there had been ongoing concerns regarding narcotic medication administrations. The HR document indicated that there had been multiple suspicious concerns and narcotic administration errors in 2016, 2017, 2018 and 2019. In August 2020, during an unrelated incident investigation by the current management team, PSW #128 brought forward the ongoing concerns they had regarding misappropriation of residents' drugs and neglect of residents. Inspector #645 also interviewed the PSW. During the interview, the PSW indicated that they observed the RN self injecting medications on two different occasions. They indicated that the first time they observed RN #127 self injecting was in 2016 and the most recent incident was in March 2020. The PSW indicated that in 2016, when they walked into a resident #015's room, they observed RN #127 lifting their shirt in the resident's washroom and attempting to self inject the medication. The washroom door was ajar and when the RN saw them walking in, they appeared to be nervous and the needle fell from their hand. The PSW walked out of the room as they couldn't believe what they saw, and returned to the room a few minutes later. When they returned to the room, they observed the RN forcefully holding resident #015's body part and the resident was

screaming and shaking vigorously. The PSW indicated that the RN seemed frozen, confused and high. The PSW grabbed the RN by their hand to free the resident. The PSW knew the resident was on a prescribed narcotic medication, was worried about the resident's safety and suspicious of drug diversion. The HR file indicated that the PSW notified the home management in September 2016. The PSW stated that since then, they observed a pattern of behaviours to suspect narcotic drug seeking behaviours in the year of 2017/18. For example, behaviours such as paying extra attention to residents who were taking narcotic medications, removing sharp disposal containers where staff members discard narcotic wastage and asking other staff members to save narcotic wastage for them. For instance, RN #129 would save narcotic wastage for RN #127. The PSW indicated that this had been an ongoing issue since 2016 and staff members knew about RN #127's behaviours, but never told the management team as they were afraid of reprisal. The PSW indicated that they reported these concerns in 2016 and on an ongoing basis but previous management did not take any actions, hence the behaviours continued. The PSW indicated that the management team labelled them as a trouble maker because they reported the RN. When they reported the incident on March 2020, where they observed the RN self injecting in the resident's washroom for the second time, they were advised by the previous ED to stop reporting as they were trying to clear RN #127's name. The PSW indicated that there was ongoing bullying towards them by RN #127 after they reported them in 2016. They indicated that they directed their complaints to the union-representative as management team did not welcome their reporting.

During the record review of the HR file, Inspector #645 was able to find a summary note written in September 2016, indicating actions taken by the home regarding narcotic diversion, but there were no interview documentations available. No evidence to support if the appropriate authorities were notified for the alleged residents abuse and neglect, narcotic diversion, and misappropriation of residents' drugs. The note indicated that the home suspected inappropriate dispensing/use of narcotic and narcotic diversion, and spoke with PSW #128, RN #127, and RN #129 in September 2016. RN #127 denied the allegations, but was disciplined, and coaching was provided on safe narcotic administration and dispensing processes. The notes also indicated that RN #127 used an identified type of needle to administer narcotics and was recommended not to use the needle, as it was not a safe method to administer

narcotics for residents. The notes also indicated that RN #129 admitted that they often left open narcotic injection vials for the on-coming RN #127 to waste, instead of wasting them with the other registered staff on the same shift. The notes indicated that RN #129 worked with three other registered staff on night shift but would choose to wait for RN #127 on the next shift. RN #129 was disciplined for their actions and education provided.

Further review of the HR records indicated that there had been multiple on-going concerns regarding narcotic medications dispensing, administering, ordering and wasting practice by RN #127. The concerns are as follows:

- In the year of 2018, the HR notes indicated that RN #127 accessed the emergency drug box (ER-Box)13 times to dispense narcotic medications, which was more frequently than the other registered staff members. Review of the ER-Box drug monitoring sheet indicated that the total number of times the ER-Box was accessed for narcotics in 2018, by all registered staff, was fifteen, and thirteen of them were accessed by RN #127.

- Summary notes from 2016, indicated that other registered staff alleged that RN #127 administered narcotic medications for residents when they don't need it and without proper pain assessment: the note indicated that RN #127 dispensed and administered narcotics to there identified residents. The notes indicated that pre or post pain assessments were not completed . No indications as to why the pain medication was given. Staff alleged that the RN administered narcotics most of the time.

- Review of a complaint letter stored in the HR file from a family member of resident #033 indicated that the family was upset because the resident was given narcotic medication. The family requested the medication to be stopped immediately. Review of the narcotic sheet indicated RN #127 administered the medication to the resident. Review of the progress note on the same day indicated that there was no pain assessment completed. There was no evidence to support if non-pharmacological approaches were attempted. No documents were available to support the reason for administering the narcotic. Review of the clinical notes indicated no documentation and no signatures on the e-MAR. There was no indication of pre or post pain assessment, and no documentation in resident #033's plan of care. The progress notes indicated that RN #127 documented an assessment as a late entry a few days later after the home

management raised the resident's family concern to RN #127. The RN indicated that they administered the narcotic medication because the resident had an identified type of illness. The notes indicated that the RN was disciplined, and educated on safe narcotics administration. The home's investigation notes indicated that the RN neglected the resident.

- Review of an HR summary note in 2019, indicated that RN #109 reported to the previous DOC that they found a syringe filled with an unidentified clear substance, stored in a residents' chart area between papers. RN #109 was suspicious that the syringe was filled with injectable narcotic fluids. The note indicated that RN #127 co-signed the narcotic waste with RN #126 and RPN #108. The note indicated that ADOC #105 investigated the incident but couldn't substantiate the allegation of narcotic diversion. There were no written statements from RN #127, RPN #108 and RN #126 available. Inspector was unable to find staff interviews and investigation documents.

- SUSPICIOUS act: 12 staff members signed a petition, in September 2018, to inform the home about suspicious actions of RN #127. The petition had the name of twelve staff members with their signatures. There were no written statements from the staff members to indicate the nature of their suspicion, and no interviews or investigation were conducted.

- Review of the Physician order in 2015, indicated that RN #127 received a new narcotic medication order for resident #011. Review of the ER box narcotic sheet indicated that the medication was dispensed and administered, and the left over medication was wasted. The records indicated that RN #127 did not sign on the e-MAR. Inspector #645 was unable to verify if the medication was administered to the resident.

- Review of the clinical notes in October 2019, indicated that resident #006 was exhibiting an identified type of behaviour and was unable to settle down. The Physician order on October 2019, indicated that RN #127 received a telephone order for a narcotic medication to help settle the resident. The notes indicated that the medication was given by RN #127. Review of the e-MAR on the same day, indicated that the e-MAR was not signed. Inspector was unable to verify who co-signed the narcotic waste with RN #127. There was no corresponding assessment completed to indicate the cause of the behaviours and if the

medication was effective after administration.

- Review of the HR note in July 2018, indicated that a narcotic medication was administered to resident #016 on two occasions. The note indicated that RN #127 dispensed and administered the medications without a second nurse co-signing the wastes on both occasions. The note also indicated that RN #127 did not sign on the e-MAR. Inspector #645 was unable to verify if the medication was administered to the resident. A disciplinary follow up note in September 2018, indicated that RN #127 was instructed to sign the e-MAR, the individual narcotic sheet and re-educated on pre/post pain assessments.

- In June 2016, the home management (previous ED) received a complainant from RN #104 regarding suspicious behaviours regarding narcotic diversion. RN #104 indicated that RN #127 was giving narcotic injections more frequently than other medications. RN #104 indicated that residents were able to take medications orally, but the RN often chose to administer narcotic injectables. RN #127 accessed the emergency drug box frequently when they received a new order. RN #104 also indicated that RN #127 took the sharp containers that had discarded narcotics to the utility room which was not a duty of the registered staff. RN #128 saved narcotic wastage to discard with RN #127 instead of other nurses on the unit. RN #104 suspected drug seeking behaviours as the RN appeared different at times, and RN #104 advised the ED to get the appropriate authorities involved and provide support for RN #127. RN #104 was concerned for residents' safety as they believed that RN #127 was administering narcotic medications to residents who did not need it.

- A performance improvement meeting was held with RN #127 in 2016 and education was provided. Email conversations between the previous DOC and the ED, in March 2016, indicated concerns with RN #127's interpersonal relationship, attitude and insubordination in the work place.

- In February 2014, missing Narcotic was reported to the home management team. The notes indicated that the DOC interviewed RN #127 and RPN #110. Inspector #645 found no investigation notes or staff interviews regarding the missing narcotic and unable to verify the outcome of the investigation.

- In March 2014, an email correspondence between the previous DOC and

management team indicated the following: staff were suspicious about narcotic diversion; RN #127 gave per-required-needed (PRNs) narcotics to residents while other staff are on break; RN #127 emptied sharp containers, and night staff left narcotics for the RN to waste. The DOC spoke with RN #107 and RN #135 regarding the missing narcotics. The email also indicated that RPN #136 would leave narcotic wastage for RN #127 to waste and when asked, RPN #136 indicated that RN #127 instructed them to do so. The HR note indicated that registered staff were advised not to give the narcotics key to RN #127 and always to keep the key with them. In the same email, the DOC indicated that there was no reason to investigate these allegations. Inspector #645 found no investigation notes for the allegation and unable to verify the outcome of the investigation. There were no written, and signed statements from the staff members describing the event. Inspector was unable to identify which residents were given narcotics when the nurses went on break. There was no record of staff interviews or investigations completed.

- The HR document from December 2015, indicated that a narcotic medication was administered to resident #004 but the wastage was not witnessed or co-signed by a registered staff. This medication was administered/dispensed by RN #127. On the document, RN #127 indicated RN #117 witnessed the wastage. The document indicated that RN #117 did not witness the waste and didn't co-sign for the above medication. There were no interviews or investigative documents available to provide details about the incident, outcome of the investigation and interventions considered to mitigate the concern. The document also indicated that a telephone order was obtained by RN #127 for the narcotic, but the medication was not transcribed, and the administration was not documented on the e-MAR. The DOC and RN #117 also questioned the need for the narcotic injection as the resident was taking oral medications at the time. The practice was identified by the DOC as inconsistent with Best Practice Guidelines for least invasive procedures. There was no corresponding assessment available to verify the need for the narcotic medication.

- Review of the HR document and the narcotic sign in/out sheet in February 2016, indicated that a narcotic medication vial was dispensed and administered to resident #010. The HR note indicated that it was unclear who witnessed the wastage. Both signatures on dispensing and waste witnessing narcotic sheet sections were identical and signed by RN #127. This medication was

administered/dispensed by RN #127 and when asked, RN #127 stated that the waste was witnessed and co-signed by RPN #110. A note in the HR file indicated that RPN #110 did not witness or co-sign on the narcotic sheet, and the signature on the sheet was not their signature. The medication administration was not signed on the e-MAR. Inspector reviewed the signatures on the narcotic sheet, and both signatures were identical with RN #127's signature. On the same day, RN #127 dispensed another narcotic medication vial and administered to resident #010. Similar to the above incident, both signatures were identical. The e-MAR was not signed.

- Review of the narcotic sign in/out sheet in February 2016, indicated a narcotic medication vial was dispensed under resident #011's name. This medication was administered/dispensed by RN #127. The narcotic sheet indicated that the wastage was co-signed, but it was unclear who co-signed with RN #127. Review of a document in the HR file indicated that the home management team spoke with RN #127 to verify the co-signer, but the RN stated they were unable to recall at the time. When RPN #110, the only nurse who worked on the same shift, was interviewed, they indicated that they did not co-sign for the narcotic waste. RPN #110 indicated that RN #127 dispensed the medication and co-signed by themselves. The document indicated that the home was unable to verify the co-signer and the reason why the medication was administered as there was no assessment completed. The document also indicated that the administration was not signed on the e-MAR. Inspector #645 reviewed the e-MAR and the clinical notes, and the e-MAR was not signed. Inspector further reviewed the documents, and there were no detailed investigation, intervention to mitigate the issue and interviews available other than the summary note in the HR file.

- In June 2019, a note from the previous DOC, indicated a narcotic medication was administered to resident #012 by RN #127 and the wastage was not co-signed by a second nurse. The Inspector was unable to identify the dosage and time of administration as the HR note did not have detailed information. The notes from DOC indicated that RN #127 dispensed the medication. Further review of the note indicated that the RN was instructed not to administer medication to residents as medication administration was a duty of a medication nurse and not the nurse in-charge. The RN was also advised to get a second nurse to witness the waste and co-sign it with another nurse.

- Record review of the progress notes and the e-MAR for resident #031 indicated that RN #127 changed the resident's medications frequently. RN #127 had sporadic ordering and discontinuation of medications without any proper documentation and assessments to support the reasons for the frequent changes. The resident was receiving narcotic capsule by mouth in October 2016, and discontinued in November 2016. On the same day, a narcotic vial was ordered. There was no indication in the resident's clinical notes regarding the ineffectiveness of the narcotic capsules prior to discontinuation.

- Record review of the progress notes and the e-MAR for resident #035 indicated that they were receiving oral narcotic capsules that was discontinued in January 2019. On the same day, another narcotic medication was ordered for the resident but the administration of the medication was not signed on the e-MAR. There was no indication in the resident's clinical notes regarding the ineffectiveness of the narcotic capsules prior to discontinuation.

- Interview with RPN #110 indicated that they were aware of the ongoing issues regarding narcotic dispensing and administration concerns. RPN #110 indicated that RN #127 tended to get an order for narcotic medications frequently and administer it to residents. The RPN remembered two incidents where they were very suspicious of the RN, as the narcotic order did not make sense to them. The RPN was unable to recall the names of the residents but indicated that on both occasions, the residents did not need the medications. There were no assessments completed to justify the need for the medications. They remembered that they couldn't justify the need for the narcotics at the time and called the physician to have them discontinued. The RPN indicated that the best practice was to initiate non-pharmacological treatments and assess residents; if the medication doesn't work, then narcotics can be considered. The RPN indicated that RN #127 always has issues with signing and co-signing narcotic medications, and these errors had been happening more frequently than normal. It was very suspicious. The RPN indicated that the home management instructed them not to give the narcotics key to RN #127. The home management team was very suspicious as well, but no actions were taken. The RPN indicated that there was a time when they worked with RN #127 and they were the only nurse working on that shift. RN #127 dispensed/administered narcotics for two residents and they did not co-sign for the wastage. They

indicated that the home management asked them if they co-signed on the document that day, but they indicated they didn't co-sign. The RPN recalled that those residents did not need the narcotic medications and they were not sure why it was given. The RPN further indicated that the RN used to empty the sharp containers where nurses dispose the wasted and unused narcotics. The RN had a practice of taking the sharp containers to the utility room or to the office in the nursing station for unknown reasons. The RPN indicated that removing sharp containers was a duty of the environmental staff members, and not the registered staff. The home management team put a locking system on the containers to prevent the RN from removing it. The RPN further indicated that they were always worried about their nursing licence and residents' safety whenever they worked with RN #127.

Interview with RN #132 indicated that RN #127 had ongoing issues with narcotic medications since 2016. RN #127 was known to give narcotics to residents that did not require it. They always had an issue with dispensing and administering the medication and co-signing the wastage with other staff members. The home management team knew about this a few years ago, but nothing was done about it. RN #132 indicated that they reported RN #127 to the home management team many times as they suspected resident neglect due to residents being given medications that they did not require. RN #132 also suspected narcotic diversion as RN #127 specifically focused on palliative residents to administer medication. They believed the RN was giving narcotics to gain access to the wastage. The RN indicated that RN #127 called the physician all the time seeking new orders for narcotic medications before trying other alternatives. There was a specific fascination about narcotic medications that would make anyone suspicious. The home management team instructed all nursing staff not to give the narcotic key to RN #127 even when going on break, as the RN tended to dispense and administer them to residents that don't need it. RN #132 stated that they never shared the narcotic key with them, and were always on high alert when the RN was on duty. RN #127 used to take the sharp containes and empty them, and when asked they always said they wanted to help. Two years ago, a family member of resident #033 was upset that RN #127 administered narcotics to the resident without their consent, and had the medication stopped immediately. Similarly, a family member of resident #031 was upset as RN #127 called and told them that their loved one needed palliative care and comfort measures, but there was no consultation with the

interdisciplinary team. RN #132 indicated that palliative care decisions are based on an interdisciplinary approach. The team will hold a care conference with nurses, physician, DOC, family members and other disciplines to discuss the benefit of palliation, and if family agreed, the physician would initiate palliative orders. In the above mentioned cases, the RN did not collaborate with the other members of the interdisciplinary team and obtained palliative orders. In 2017 and 2018, RN #127 was instructed not to give medications to residents as the home management was suspicious about narcotic diversion, but the RN continued to give medications regardless. RN #132 indicated that another RN from a different shift would save narcotic waste for them instead of wasting and co-signing it with another nurse on the same shift. RN #132 described RN #127's behaviour as strange; they arrived early to their shift or stayed late; they sometimes talked too much or was completely withdrawn. They were either extremely happy or cranky.

Interview with RN #104 indicated that they were always suspicious of RN #127 regarding narcotic dispensing and administration. RN #127 administered narcotics to residents frequently and put residents at risk. RN #104 indicated that RN #127 had a habit of getting a new orders for narcotics without completing the necessary assessments, then access the emergency drug box. On many occasions, the RN did not utilize the non-pharmacological methods or use non narcotic medications to manage residents' pain. They always had issues with signing on the e-MAR and getting someone to witness the wastage. They removed and emptied the sharp containers on the floor very frequently. They reported these concerns a few times and advised the home management team to get the appropriate authorities involved, and provide help for the RN. RN #104 described RN #127's behaviour as disengaged, and at times, extremely friendly.

Interview with RN #117 indicated that all staff members including RNs, RPNs and PSWs were aware of the suspicious behaviours of RN #127. The RN stated that one day in 2016, prior to going on their break, they gave the narcotics key to RN #127 after counting the narcotics. When they came back, they noticed one narcotic injectable vial was missing, and the narcotics sign out sheet was not signed. The RN indicated that they were nervous and asked RN #127 about the missing vial. RN #127 initially responded by saying they did not know anything about the missing vials, then later changed the story and stated that the narcotic

vial fell on the floor and broke. RN #117 stated that they couldn't believe what they heard and started asking questions such as: why RN #127 opened the narcotic locker, if anyone witnessed the vial breaking, and who cleaned up the broken vials? RN #117 indicated that RN #127 responded angrily that the vials were broken, and no one witnessed it and then walked away. RN #117 indicated that they reported the incident to the management team as the RN lied initially and they were suspicious of narcotic diversion. They indicated, at the time, that there was no resident that required the narcotic medication and there was no reason to open the narcotic locking system. In addition, if the narcotic vial broke, the expectation was to get another registered staff to witness and waste it. In this case, there was no witness and no one co-signed. RN #117 indicated they remembered another incident approximately in the year of 2015/16 when RN #127 dispensed and administered a narcotic medication to resident #004, but the e-MAR was not signed and the narcotic sheet for the waste was not co-signed. They stated that they could not believe that no actions were taken despite many reports of residents' neglect, and suspicious behaviours.

Interviews with PSW #133 and #134 indicated that they both observed suspicious behaviours and were aware about the ongoing narcotic issues with RN #127. PSW #133 indicated that they had observed RN #131 giving open medication vials to RN #127 on one occasion. The PSW indicated that one morning, they observed RN #127 reaching into their purse in the nursing office after RN #131 gave the medication vials to them. They were not sure if the RN placed the vials in their purse but they were very suspicious. The PSW indicated that RN #127 was very attentive to residents who were palliative or residents that were receiving narcotic medication. PSW #134 stated that on one occasion, while they were in the middle of providing care for a resident, RN #127 barged in the room. The RN seemed confused and nervous, then they quickly walked out of the room. A minute later, the RN returned to the room and told them to leave. PSW #134 stated that they were puzzled by the RN's request and asked the reason. The RN responded by saying they have to use the resident's bathroom. The PSW indicated that they left the room but was suspicious that the RN was up to something as the behaviour was strange. They indicated that no other staff member would use the residents' washroom as there were staff washrooms available.

During the course of this inspection, record reviews and interviews, the

inspectors were able to gather the following information. Multiple staff members indicated ongoing concerns regarding RN #127's narcotic dispensing, administration and diversions. The records indicated that these concerns were ongoing from the year of 2015 to 2020. Staff members alleged residents neglect, and reported to the home management team on more than one occasion. Multiple staff members signed a petition to express their concern about RN #127 suspicious behaviours, and reported to the home management team. Staff members advised the home management team to notify the appropriate authorities and provide help to the RN. Review of residents' records indicated that multiple residents were administered narcotics by RN #127 without indication of pain or without proper pain assessments. Residents were given injectable narcotics when they could take oral medications. Review of the e-MAR record for multiple residents indicated that the administration of narcotics were not recorded or signed. There had been ongoing issues with signing and co-signing of narcotic wastage. There had been concerns from staff members that the RN #127 administered narcotics to residents when they didn't need it. Staff members alleged that the RN administered narcotics when they went on their break. Staff members reported multiple concerns regarding residents' safety and well-being. Staff members suspected narcotics diversion as the RN removed sharp containers from the medication carts on multiple occasions. Staff observed the RN self administering medication in residents' bathroom on two occasions. Review of records indicated that the MLTC and police were only notified in August 2020 after new management took over the home. The home had reasonable ground to suspect narcotic diversion and residents neglect since 2016 but failed to report to the MLTC and police in a timely manner. Review of the HR document indicated a few documentations and fact-finding summary notes. Inspector #645 was unable to locate written, signed and dated statements from staff members describing each allegation; there were no staff interviews available; and no investigation records for the incidents. The RN continued administering medications despite the fact they were instructed not to administer medications; medication errors and narcotic dispensing, and administration concerns continued; residents were given narcotic medications without proper assessment and the RN failed to use less invasive approaches; residents neglect and risk continued, and the home failed to protect the residents and implement the home's abuse policy. The RN continued exhibiting narcotic diversion behaviours that are outlined in the home's policy. [s. 20. (1)]

The severity of the noncompliance was identified as actual risk or harm as controlled substances were not accurately accounted for, and resident medications were not administered as scheduled. The scope of the noncompliance was identified as widespread as more than three residents reviewed were affected. The home's compliance history over the past 36 months showed the home had been issued noncompliance related to this subsection.

(645)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

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 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 21st day of December, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Derege Geda

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