Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2019	2019_736689_0013	022970-17, 023243-17, 023655-17, 000032-18, 003168-18, 023852-18, 007334-19	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Brant Centre Long Term Care Residence
1182 Northshore Blvd. East BURLINGTON ON L7S 1C5

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

CASSANDRA ALEKSIC (689), MEAGAN MCGREGOR (721)

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): April 15, 16, 17 & 18, 2019.

The following intakes were completed in this Critical Incident System Inspection:

Related to responsive behaviours:
Critical Incident Log #023655-17 / CI 2900-000017-17;
Critical Incident Log #022970-17 / CI 2900-000010-17;
Critical Incident Log #023243-17 / CI 2900-000012-17;
Critical Incident Log #000032-18 / CI 2900-000026-17

Related to hospitalization and change in condition:
Critical Incident Log #003168-18 / CI 2900-000006-17

Related to medications:
Critical Incident Log #023852-18 / CI 2900-000013-18;
Critical Incident Log #007334-19 / CI 2900-000001-19

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Pharmacy Consultant, Registered Practical Nurses, and Personal Support Workers.

The inspectors also observed residents and the care provided to them, reviewed health care records, and reviewed policies and procedures of the home.

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

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

- **3 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy was complied with.

Ontario Regulation 79/10 s. 114 (2) states, "The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home."

Ontario Regulation 79/10 r. 136 (1) states, “Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of drugs.”

Ontario Regulation 79/10 r. 136 (2) states. “The drug destruction and disposal policy must also provide for the following: 1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. 2. That any controlled substance that is to be destroyed and disposed of shall be stored in a double-locked storage area within the home, separate from any controlled substance that is available for administration to a resident, until the destruction and disposal occurs.”

Ontario Regulation 79/10 r. 136 (3) states “The drugs must be destroyed by a team

acting together and composed of (a) in the case of a controlled substance, one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist."

Ontario Regulation 79/10 r. 136 (6) states, "For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable."

Specifically, staff did not comply with the home's "Narcotics" policy number LTC-CA-WQ-200-05-14, and "Order/Re-ordering/Destruction of Drugs; Drug Record Book" policy number LTC-CA-WQ-200-06-16, last revised December 2017, which is part of the licensee's medication management program.

A) Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date documented two incidents of "Controlled Substance missing/unaccounted."

The CIS report documented that the narcotic patch for resident #005 was not accounted for on a specific date during a narcotic count sheet review completed on a specific date. The CIS stated that a Registered Practical Nurse (RPN) who worked that shift signed the electronic Medication Administration Record (eMAR) that the patch was removed, but failed to sign the patch removal on the narcotic count sheet. The report documented that the RPN stated they disposed of the narcotic patch in a yellow sharps container instead of following the process of narcotic destruction. The CIS report documented another incident on a specific date, a Registered Nurse (RN) noted that the narcotic patch had been removed from resident #004 was also missing from the narcotic count sheet. The report documented that the RPN advised the home that they had forgot/had not been thinking and had thrown it out in the garbage.

Physician Orders reviewed in Point Click Care (PCC) for resident #004 and showed the directions for a narcotic patch, with a specific order date.

The home's investigation notes showed the following documentation related to the CIS report for resident #004:
-Medication Incident Report for resident #004 with a specific date of incident, showed "Analysis of incident": Staff disposed of the narcotic patch in garbage instead of following proper procedure for disposal.
-An email statement to the Administrator from an RPN on a specific date stated on that

date, at the morning medication pass, they had removed the narcotic patch from resident #004 and put on a new one. The note stated that at the end of the medication pass, they put the medication cart in the medication room and when they cleaned up their cart, they threw the patch away in the garbage bin.
-The narcotic destruction sheet for resident #004 on a specific date, showed a handwritten note which stated that the resident's first patch was thrown out by the RPN.

The clinical records were reviewed in PCC for resident #005 and showed an order for narcotic patches, with a specific order date.

The home's investigation notes showed the following documentation related to the CIS report for resident #005:
-The Medication Incident Report for resident #005 with a specific date of incident showed a "Written Description of Incident" which stated that the writer reviewed the medication narcotic record noted on a specific date that the narcotic patch was not signed and they were unable to locate the removed patch. The report stated under "Type of Incident" documentation of improper disposal on a specific date and that the patch was missing.
-The Resident's Individual Narcotic and Controlled Drug Count Sheet "Apply" for resident #005 showed documentation that a narcotic patch was applied on specific dates. The document did not have a registered staff signature on a specific date, under the heading "Signature of Person Administering or Receiving Medication."
-The Resident's Individual Narcotic and Controlled Drug Count Sheet "Removed Patches" for resident #005 showed documentation that the narcotic patch was removed on specific dates. The document did not have a registered staff signature on a specific date under the heading "Signature of Person Administering or Receiving Medication."
-The narcotic destruction sheet for resident #005 showed no narcotic patch on the destruction sheet for a specific date.
-The Narcotic and Controlled Substance Shift Count showed no documentation or registered staff signatures for resident #005 on a specific date.

On a specific date, a Registered Practical Nurse (RPN) stated that the process in the home for the destruction of narcotic patches was that the old patch would be removed on the same day that the new patch was applied to the resident. The RPN stated that the removed patch would be put onto the narcotic destruction sheet and brought to a specific home area where the pharmacy narcotic destruction box was located. The RPN stated that the registered nurse on the unit would sign as the second staff member and then the medication would be put into the destruction box. When asked how many registered staff completed the narcotic count sheets, the RPN stated that two registered staff would sign

and complete the count sheets each shift. The RPN reviewed the eMAR for resident #005 and stated that on a specific date, the narcotic patch was provided to the resident as per the records. The RPN stated they would expect that the Resident's Individual Narcotic and Controlled Drug Count Sheets for resident #005 should have been signed on the specific date, by the registered staff when the previous patch was removed and the new patch applied. The Narcotic and Controlled Substance Shift Count documentation was reviewed by the RPN and they stated the application and removal of the narcotic patch was not documented on the records for the specific date. The RPN reviewed the narcotic destruction document for resident #005 and stated the patch that was applied to the resident on a specific date, and removed on a specific date, was missing from the records. The RPN stated that the registered staff member did not follow the home's process for destruction of controlled substances.

The home's policy "Narcotics", policy number LTC-CA-WQ-200-05-14 last revised December 2017 documented that used narcotic patches for discard were to be removed from the resident, affixed to the contracted pharmacy form. The policy stated that two registered staff must sign on the Narcotic count sheet confirming the disposal and that the form with the patch attached was then placed in the designated double locked location for destruction of controlled substances. The policy stated that both nurses were to be present when the used patch was placed into the secured container for controlled drug destruction.

On a specific date, the Director of Care (DOC) stated that for the disposal of narcotic patches, the patch was to be removed from the resident and affixed to the narcotic destruction form provided by the pharmacy. The DOC stated that once affixed to the form, the patch was put into the narcotic container awaiting destruction in a locked cabinet separate from other narcotics. The DOC stated that two nurses must witness the disposal of the narcotic patch and sign the log records for narcotic destruction. When asked if the information provided regarding the process of the destruction of narcotics was based on the home's policy, the DOC stated yes.

On a specific date, the Administrator stated that the home's process related to the destruction of narcotic patches was not followed for resident #004 and resident #005, and that the expectation was that the patches would have been attached to the destruction sheet and disposed of properly. The Administrator confirmed that the narcotic patches were not destructed as per the home's policy.

The licensee has failed to ensure that the narcotic patches that were removed from

resident #004 and resident #005 were placed in the designated double locked location for destruction of controlled substances and that two registered staff were present and signed the narcotic count sheet confirming the disposal of the controlled drugs as per the homes Narcotic policy.

B) Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, documented a "Controlled Substance missing/unaccounted" for resident #006.

The home's investigation notes showed the following documentation related to the CIS report for resident #006:
- The Medication Incident Report showed the specific date of incident and stated "Written Description of Incident: 1700 medication was not given to resident, signed in PCC but not given."
-A handwritten note documented by a RPN stated that they had discarded the pill in the destruction bin.

The clinical records for resident #006 were reviewed in Point Click Care (PCC) and showed a medication order for a narcotic capsule with a specific order date.

On a specific date, the Assistant Director of Care (ADOC) stated that the process for the destruction of narcotics was that the registered staff would document the reason for destruction in the electronic Medication Administration Records (eMAR) and have a second registered staff witness and sign for the medication destruction. The ADOC stated that on a specific date, they were informed by a RPN that resident #006's narcotic capsule from a specific date was still in the resident's medication card and at that time was not discarded. The ADOC stated that on another specific date, they observed the medication card for resident #006 and the medication which should have been in the 1700 hour slot for a specific date, was now missing. The ADOC stated that after reviewing the information, the RPN informed the ADOC that they had thrown out the medication, unwitnessed, into the medication room Sharpsmart destruction bin. The ADOC stated that there were no records completed of this medication destruction for the narcotic capsule on the specific date. The ADOC stated that they went through the medication room destruction bin and found the loose capsule. When asked if the home's process for medication destruction of narcotics was based on the home's policy, the ADOC stated yes and confirmed the process was not followed by the RPN.

The home's policy "Narcotics, LTC-CA-WQ-200-05-14" last revised December 2017

documented that "In the event the medication prepared for the resident is not administered, two Registered Staff must witness the destruction of the medication." "All narcotics/controlled drugs are counted until the discontinued drugs are removed by Director of Care or designate to a locked Narcotic surplus drawer/cabinet in a locked room. Prior to placing the discontinued narcotics in the locked area, the DOC and a Registered Staff will complete the Log Record of Narcotics for Destruction."

The Log Record of Narcotics for Destruction was reviewed and showed no documentation for the destruction of resident #006's narcotic capsule on a specific date.

On a specific date, the Director of Care (DOC) stated that two signatures were needed for the destruction of narcotics or controlled substances. The DOC stated that the medication would be put into a bag and brought to a specific home area where the registered staff would call the registered nurse on duty to come and witness the medication to destruct and then sign the narcotics for destruction form and put the medication into the locked destruction box. The DOC confirmed the details of the CIS report as per the information provided by the ADOC and stated that a RPN admitted that they put resident #006's narcotic capsule into the SharpSmart container. When asked if two staff witnessed the wasting of the medication and if it was documented on the narcotic count sheets as per the home's process, the DOC stated no. When asked if the information provided regarding the process of the destruction of narcotics was based on the home's policy and procedures, the DOC stated yes, and that the home's process for medication destruction was not followed by the RPN.

The licensee has failed to ensure that the destruction of resident #006's narcotic medication was witnessed by two registered staff, was locked in a narcotic surplus drawer/cabinet in a locked room, and had the DOC and a registered staff complete the Log Record of Narcotics for Destruction as per the home's policy.

C) Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date documented a "Controlled Substance missing/unaccounted" for resident #006. Through information gathering, the Inspector was provided information related to the home's process for destroying narcotic and controlled substances.

On a specific date, the Assistant Director of Care (ADOC) stated that the Registered Practical Nurse (RPN) had disposed of the resident #006's narcotic capsule into the medication room destruction bin. The ADOC stated that they went through the

medication destruction bin and found the narcotic capsule.

On a specific date, the Inspector asked a RPN about the process in the home for the destruction of controlled medications. The RPN stated that the medication destruction would be documented on the residents individual narcotic count sheets, signed off by two registered staff and then taken to a specific home area for disposal. When asked about controlled medications that were, for example, punched out of the resident's medication card and then refused or any loose narcotics to be discarded, the RPN stated that the documentation would still be completed for narcotic destruction and the medication would go into the Sharpsmart container.

On a specific date, a RPN stated that if a controlled medication was out of the medication card but not administered to a resident, then staff would document on the individual narcotic and controlled substance count sheets under quantity wasted, document on the medication destruction record form, document on the residents electronic Mediation Administration Record (eMAR) the reason for not administering the medication, and then dispose of medication in the Sharpsmart container. The RPN stated that they would put the controlled medication into the SharpSmart if it was a dry capsule, if it was mixed with applesauce, or if it was spit up by the resident.

On a specific date, the ADOC stated that controlled substances, such as narcotic patches, as well as narcotics that are not opened, for example in vials or blister packs are disposed of in the destruction locked box on a specific home area. The ADOC stated that any loose, crushed or prepared narcotics not administered to residents are put into the Sharpsmart container in the medication rooms. The ADOC stated that Daniels who was a partner of the home's contracted pharmacy, would come into the home as per the waste pick up schedule, pick up the Sharpsmart medication destruction bins and they would destroy the medications. When asked if a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable, the ADOC stated yes. The ADOC stated that medications in the Sharpsmart containers were not destroyed in the home.

On a specific date, the Director of Care (DOC) confirmed that a RPN admitted that they had put resident #006's narcotic capsule into the Sharpsmart container on a specific date. The DOC stated that they brought the Sharpsmart container to their office and contacted the pharmacy consultant and inquired how to break into the container. The DOC stated that they lifted the springs off the container and when it was undone, lifted the lid off. The DOC stated that they had found the loose intact capsule in the

Sharpsmart container.

On a specific date, with the ADOC present, the DOC stated that controlled medications if loose capsules, prepared, or refused by a resident may be destructed in the Sharpsmart container with the non-controlled medications as long as they are accounted for the on the drug destruction records. The DOC stated that the pharmacist consultant would complete the narcotic destruction with the ADOC. The DOC stated that they would take the medication out of the locked cabinet on a specific home area, match the narcotic waiting destruction form with the medications in the destruction bin and then water would be poured onto the medications in a bucket. When asked if medications that were placed into the Sharpsmart containers were destroyed in the home, the DOC stated that they were destroyed out of the home. The inspector asked if a drug was considered to be destroyed if it was altered or denatured to such an extent that its consumption would be rendered impossible or improbable, and the DOC stated yes. The Inspector and the DOC reviewed the home's policy titled "Narcotics" LTC-CA-WQ-200-06-14 with reviewed date December 2017 and read the policy which stated "All narcotics must leave the home in a form that is not usable." When asked if water was added to the Sharpsmart containers by staff before locking them, the DOC stated that no water was added to the Sharpsmart containers. When asked if the Sharpsmart containers, which contained controlled medications, were not destroyed in the home then was the home following their policy with regards to all destroying narcotics, the DOC stated that the containers were locked and have one-way access and therefore not able to be removed from the container.

During a telephone interview on a specific date, the Pharmacist Consultant (PC) stated that they were the pharmacist consultant for the home and completed the home's narcotic destruction. The PC stated that staff could put narcotics into the Sharpsmart container if it was a loose tablet, for example if a resident had refused the medication, but two staff were needed to document for the medication destruction. When asked if the home destroyed the medications in the Sharpsmart containers, the PC stated no, that the home was not destroying the medications in these containers. When asked how the home was ensuring that according to the home's policy that all narcotics were destroyed before leaving the home if staff were putting controlled substances into the containers, the PC stated that once the tablet was in the bin it could not be retrieved, and stated "but I see what you mean."

The home's policy "Order/Re-ordering/Destruction of Drugs; Drug Record Book", policy number LTC-CA-WQ-200-06-16 last revised December 2017 documented that "All narcotics/controlled drugs must be rendered useless prior to leaving the home." The

home's policy "Narcotics", policy number LTC-CA-WQ-200-05-14 last revised December 2017 documented that all narcotics/controlled drugs are counted until the discontinued drugs are removed by Director of Care or designate to a locked Narcotic surplus/cabinet in a locked room."

The licensee has failed to ensure that controlled substances that were disposed of in the Sharpsmart containers were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and a physician or a pharmacist as per the home's policies. [s. 8. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (3) The drugs must be destroyed by a team acting together and composed of,
(b) in every other case,
(i) one member of the registered nursing staff appointed by the Director of Nursing and Personal Care, and
(ii) one other staff member appointed by the Director of Nursing and Personal Care. O. Reg. 79/10, s. 136 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a drug, which was not a controlled substance was to be destroyed, it was done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing.

Ontario Regulation 79/10 r. 136 (6) states, "For the purposes of this section a drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable."

Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date documented a "Controlled Substance missing/unaccounted" for resident #006. Through information gathering, the Inspector was provided information related to the home's process for destroying non-controlled substances.

On a specific date, a Registered Practical Nurse (RPN) stated that the home's process for the destruction of non-controlled substances was that the medication destruction record form would be completed and signed by two registered staff who witnessed the medication destruction, and then the medication was put into the Sharpsmart container located in the medication room.

On a specific date, the Assistant Director of Care (ADOC) stated that Daniels who is a partner of the home's contracted pharmacy, would come into the home as per the waste pick up schedule, pick up the Sharpsmart medication destruction bins and they would destroy the medications. When asked if a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable, the ADOC stated yes. The ADOC stated that medications were not destroyed in the home.

On a specific date, the Director of Care (DOC) stated that the Sharpsmart containers were for the disposal of non-controlled substances and when full, the lid was closed and locked. The DOC stated that the medications were not destroyed in the home and Daniels would take the containers out of the home for destruction. When asked if a drug was considered to be destroyed when it was altered or denatured to such an extent that its consumption was rendered impossible or improbable, the DOC stated yes and that this was not completed in the home. When asked by the inspector on a specific date, if drugs were destroyed by a team acting together and composed of one member of the registered staff and one other staff member, the DOC stated that non-controlled drugs were not destroyed on site by two staff members of the home.

The licensee has failed to ensure that non-controlled substances disposed of in the Sharpsmart containers were destroyed by a team acting together and composed of one member of the registered nursing staff appointed by the Director of Nursing and Personal

Care and one other staff member appointed by the Director of Nursing. [s. 136. (3) (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 when a drug, which is not a controlled substance is to be destroyed, it was done by a team acting together and composed of: one member of the registered nursing staff appointed by the Director of Nursing and Personal Care and one other staff member appointed by the Director of Nursing, to be implemented voluntarily.

WN #3: 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 residents in accordance with the directions for use specified by the prescriber.

Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, documented a "Controlled Substance missing/unaccounted" for resident #006.

The home's investigative notes showed documentation of a Medication Incident Report with date of incident a specific date for resident #006. The report documented "1700 medication was not given to resident, signed in PCC (Point Click Care) but not given."

On a specific date, a Registered Practical Nurse (RPN) stated that when completing the morning medication pass on a specific date, they noticed that a narcotic capsule was in resident #006's blister pack for a specific date, at 1700 hours. The RPN stated that they

reviewed the residents electronic Medication Administration Record (eMAR) on the specific date, which documented that the medication was provided and administered. The RPN stated that they informed the Assistant Director of Care (ADOC), completed a medication incident report, circled and left the medication in the residents' blister pack. The RPN stated that the expectation for when a medication was missed or not provided to a resident as per the order was to check the eMAR to see if the medication was given, complete the medication incident report and then report the missed medication to the management, pharmacy and the family. When asked if the residents' narcotic mediation was provided to the resident as per the physicians order on the specific date, the RPN stated no.

The clinical records for resident #006 were reviewed in Point Click Care (PCC) and showed a medication order for a narcotic capsule with a specific order date. The order summary stated "Give one (1) capsule by mouth two times a day for Prescriber to specify" and pass times were documented as 0800 hours and 1700 hours. The eMAR for resident #006 showed documentation that the narcotic capsule was "administered" on a specific date at 1700 hours.

On a specific date, the Director of Care stated that a Registered Practical Nurse (RPN) missed giving the 1700 hour dose of their narcotic medication to resident #006 on a specific date. The DOC stated that on a specific date, during the 0800 hours medication administration, the RPN identified the narcotic capsule on a specific date was still in the medication card for 1700 hours. The DOC stated that on another specific date, the Assistant Director of Care (ADOC) went to observe the missed dose in the medication card, but the capsule was missing. The DOC stated that after the ADOC discussed the incident with the RPN, the RPN admitted that they put the narcotic capsule into a SharpSmart container. The DOC stated that the medication was not provided to the resident as ordered on a specific date and was a medication error.

The licensee has failed to ensure that resident #006 was administered their narcotic medication in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Ontario

Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.