Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 15, 2016	2016_389601_0017	020028-16	Complaint

Licensee/Titulaire de permis

PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
1090 MORAND STREET WINDSOR ON N9G 1J6

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

REGENCY MANOR NURSING HOME, DIVISION OF PROVINCIAL NURSING HOME LIMITED PARTNERSHIP
66 DORSET STREET EAST PORT HOPE ON L1A 1E3

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

KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 27, 28 and 29, 2016.

This inspection is related to complaint log #020028-16 regarding resident care, medication administration and allegations of resident to resident alleged sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI Coordinator, Pharmacist, CCAC Representatives, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW).

The Inspector conducted a tour of one home area, observed staff to resident interaction, reviewed resident clinical health records and applicable policies.

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 #001 in accordance with the directions for use as specified by the prescriber.

During an interview, resident #001's spouse indicated that resident #001 required an identified medication at supper time to manage a medical condition. Resident #001's spouse indicated speaking to RPN #110 on the identified date and time regarding resident #001's supper time medication. According to resident #001's spouse, RPN #110 had indicated that resident #001 had not received the identified medication at supper time due to the medication not being transcribed onto the Medication Administration Record (MAR).

Review of resident #001's MAR identified that RN #103 transcribed the Physician orders at approximately 2235 hours on the identified date. Resident #001's admission Physician orders included to administer the identified medication at 0800 hour and 1700 hour for the identified medical condition.

Review of resident #001's progress note documented by RPN #110 on the identified date at 2215 hours identified that RPN #110 administered resident #001's identified medication at approximately 2210 hours.

During an interview, RN #103 indicated that resident #001's admission Physician orders were not transcribed until approximately 2230 hours on the identified date. Therefore, resident #001 did not have a MAR until approximately 2230 hour on the identified date and RPN #110 was not prompted to give the medication at 1700 hours as prescribed.

Therefore, resident #001 did not receive the identified medication at the 1700 hour supper meal as prescribed to manage the resident's medical condition.

2. Review of resident #001's New Admission Order Form identified that resident #001 had a Physician order for an identified medication one tablet every morning and one tablet at bedtime for an identified medical condition.

Review of resident #001's Medication Administration Record (MAR) for an eight day period identified that on an identified date, RN #103 transcribed the Physician's order and entered the identified medication as three tablets at bedtime onto resident #001's MAR.

On five identified dates, RPN #117 had signed the MAR indicating that resident #001 had received three tablets of the identified medication at 2000 hours. During an interview, RPN #117 indicated that resident #001's medication was administered from the pill

bottles from home and resident #001 had received three tablets of the identified medication on the five identified dates as directed on resident #001's MAR.

Therefore, on five identified dates RPN #117 administered three tablets of the identified medication as directed on the Medication Administration Record instead of one tablet as prescribed by the Physician. [s. 131. (2)]

3. Review of resident #001's New Admission Order Form identified that resident #001 had a Physician order for an identified medication one tablet every morning and one tablet at bedtime for an identified medical condition.

During an interview, RPN #104 indicated noticing resident #001's medication pill bottle from home had an administration time of 0800 and resident #001's MAR did not have the identified medication scheduled for 0800 hours. RPN #104 verified the Physician order with the New Admission Order Form and notified RN #103 of the transcription error. RPN #104 indicated working the day shift prior to noticing the transcribing error and resident #001 had not received the identified medication at 0800 hour.

Review of resident #001's MAR identified that RN #103 transcribed the identified medication to be given at 0800 hours on the same day RPN #104 noticed the transcription error.

Therefore, on one identified date at 0800 hour, RPN #104 did not administer resident #001's identified medication as prescribed by the Physician. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to resident's in accordance with the directions for use as specified by the prescriber, to be implemented voluntarily.

WN #2: 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 comply with O. Reg. 79/10, s. 8(1) (b) in that the home did not ensure that their policy related to medication administration was followed to ensure safe, effective administration of resident #001's medication.

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

Review of the home's Medication Practices policy # RC-5.080 related to "Physician Orders" directed that the RN/RPN will verify the order is complete or follow up with the prescriber to obtain a complete prescription; initial to the side of the order to indicate that the order is transcribed and sign in the designated space on the Physician's order sheet; process each physician's order immediately and co-sign for accuracy as soon as possible, within twenty-four hours; flag new orders by pulling the doctor's order tab in the binder chart and leave in place until the second nurse has verified that the order has been transcribed accurately and the order processed though to pharmacy.

Resident #001 was admitted to the home and required medication to be administered as a treatment for an advanced medical condition.

During an interview, Resident #001's spouse indicated informing the registered staff that the medication treatment was to be administered for an identified period of time.

Review of resident #001's "New Admission Order Form" indicated the licensee's attending Physician had prescribed resident #001's medication treatment to be

discontinued at a specified time but did not prescribe the identified period of time.

Review of resident #001's Medication Administration Record (MAR) identified that RN #103 had transcribed resident #001's Physician order regarding the identified medication treatment to be administered and discontinued at identified times.

During an interview, RN #103 indicated no awareness the prescribing Physician had not prescribed an administration time for resident #001's medication treatment. RN #103 indicated working evenings on a regular basis and the medication treatment was discontinued as directed by resident #001's spouse. RN #103 indicated not verifying resident #001's administration time with the Physician and did not document on resident #001's MAR or any other record the time resident #001's medication treatment was discontinued.

During an interview, RN #105 indicated working days on a regular basis and the medication treatment was administered as directed by resident #001's spouse. RN #105 indicated no awareness that the prescribing Physician had not prescribed an administration time for resident #001's medication treatment. RN #105 indicated not verifying resident #001's administration time with the Physician and did not document on resident #001's MAR or any other record the time resident #001's medication was administered.

During an interview, RN #103 indicated transcribing resident #001's Physician orders on the identified date and time.

Review of the Physician's order sheet "New Admission Order Form" identified that there was no initial to the side of the order to indicate that resident #001's Physician orders had been transcribed or that a second nurse had verified that resident #001's physician order had been transcribed accurately.

Therefore, on the identified date the attending Physician prescribed a medication treatment for resident #001 and the specific direction only included a discontinuation time. During an interview, RN #103 and RN #105 indicated that they did not follow up with the prescriber to obtain a complete prescription, did not sign to indicate the order had been transcribed or co-sign for accuracy of transcribing of resident #001's Physician orders as per the home's medication administration policy. [s. 8. (1) (b)]

Issued on this 31st day of August, 2016

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

Original report signed by the inspector.