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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2017	2017_589641_0035	020906-17	Critical Incident System

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
c/o Southbridge Care Homes, 766 Hespeler Road, Cambridge, ON N3H 5L8

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

REGENCY LONG TERM CARE HOME
66 DORSET STREET EAST PORT HOPE ON L1A 1E3

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

CATHI KERR (641)

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): October 25, 26, and 27, 2017

This inspection was conducted in reference to a critical incident, Log # 020906-17 related to medication incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, Registered Nurses, and Registered Practical nurses. As well, the Inspector reviewed resident heath care records and supplemental staffing agreement with a staffing agency provider.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	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 residents in accordance with the directions for use specified by the prescriber.

The Director of Care (DOC) contacted the Ministry of Health and Long-Term Care's after hours pager on a specified date and subsequently submitted a Critical Incident Report (CIR) #2511-000005-17 to the Director regarding an incident in the home related to multiple residents not receiving their medication on that day.

On a specified date, the home was unable to fill the 0700 to 1500 RPN shift on Unit A, with their own staff and had contacted a staffing agency provider who supplied the home with RPN #101. At the end of the shift at 1500, the oncoming RN #103 was notified by RN #102, that RPN #101 had not given medications to a large number of residents. RN #103 notified the Director of Care (DOC) and initiated medication incidents for all of the residents who had not received their medications.

Inspector #641 interviewed RN #102 on October 25, 2017. RN #102 indicated that on a specified date, she was working on the first floor which had 20 residents and RPN #101 was working on the second floor, Unit A, which had 40 residents. RN #102 indicated that she went up to the second floor after 0900 hours and RPN #101 indicated to her at the time that he was a little behind with administering the resident's medications because he didn't know the residents. RN #102 wasn't concerned at that point because he was new. RN #102 signified that RPN #101 did not ask for help or suggest that he was overwhelmed at that time.

RN #102 signified that she was back on the second floor before lunch to do treatments on the unit and RPN #101 hadn't indicated to her that he was behind with administering the resident's medications. RN #102 acknowledged that sometime between 1230 and 1300, RN #102 went upstairs and assessed the situation and realized only 8-9 residents had received their medications at that point. RN #102 indicated that the oncoming RN #103 arrived about 1440 and she informed RN #103 about the medications not being given on the second floor. RN #102 indicated that RN #103 took over at this point and notified the DOC and initiated the incident reports.

Inspector #641 interviewed RN #103 on October 25, 2017. RN #103 indicated that when she arrived at the home at about 1440 on the specified date, RN #102 told her that the agency RPN was still giving out 0800 medications. RN #103 had asked RPN #101 why he hadn't asked for help but he didn't give her an answer, just that he didn't know the residents. The RN told him that the residents had arm bands, their picture was in the MAR and the PSW's all knew the residents and were a source for identification that he should have used. RN #103 indicated that she immediately notified the DOC and then

notified the doctor on call for the home of all the medication omissions. The doctor agreed that other than one medication that he ordered to be given at that time, all other doses were not to be given. RN #103 indicated that all the families were notified of the omissions and each of the residents were assessed.

Inspector #641 reviewed the e-MAR (electronic Medication administration record) and a paper copy of the e-MARs, for the residents on Unit A for the 0700 to 1500 shift on a specified date. There were 26 residents identified who had not received some or all of their medications during that shift. The agency RPN did not have computer access so he had documented his medication pass on a paper copy of the eMAR. For the following 26 residents, there was no documentation that RPN #101 had given some or all of their medications:

Resident #001 did not receive two medications as prescribed at 1200.
Resident #002 did not receive three medications as prescribed at 0800.
Resident #003 did not receive six medications as prescribed at 0800 and one medication at 1200.
Resident #004 did not receive one medication as prescribed at 0800 and 1200.
Resident #005 did not receive four medications as prescribed at 0800.
Resident #006 did not receive one medication as prescribed at 0800 and one at 1200.
Resident #007 did not receive one medication as prescribed at 1200.
Resident #008 did not receive three medications as prescribed at 0800 and one at 1200.
Resident #009 did not receive four medications as prescribed at 0800 and five at 1200.
Resident #010 did not receive six medications as prescribed at 0800.
Resident #011 did not receive one medication as prescribed at 0800 and one at 1200.
Resident #012 did not receive two medications as prescribed at 0800 and one at 1200.
Resident #013 did not receive five medications as prescribed at 0800.
Resident #014 did not receive six medications as prescribed at 0800 and one at 1200.
Resident #015 did not receive eight medications as prescribed at 0800.
Resident #016 did not receive six medications as prescribed at 0800 and one at 1200.
Resident #017 did not receive one medication as prescribed at 0800 and two at 1200.
Resident #018 did not receive four medications as prescribed at 0800 and one at 1200.
Resident #019 did not receive ten medications as prescribed at 0800.
Resident #020 did not receive ten medications as prescribed at 0800 and two at 1200.
Resident #021 did not receive five medications as prescribed at 0800 and two at 0900.
Resident #022 did not receive three medications as prescribed at 0800 and one at 1200.

Resident #023 did not receive seven medications as prescribed at 0800 and one at

1200.
Resident #024 did not receive four medications as prescribed at 0800.
Resident #025 did not receive three medications as prescribed at 0800.
Resident #026 did not receive six medications as prescribed at 0800 and one at 1200.

During an interview with Inspector #641 on October 25, 2017, the Director of Care (DOC) #100 indicated that on a specified date, a staffing agency provider, sent RPN #101 to work the day shift, arriving at 0500 for a two hour orientation just prior to starting the shift at 0700. The DOC specified that she realized after the shift was over that RPN #101 had not had the eight hour orientation to the home that was required under the agency's contract with the licensee.
The DOC indicated that the doctor on call for the home had been contacted and he indicated that he was not concerned about most of the medications that hadn't been given, but to give one specific medication, to resident #014.
DOC #100 indicated that the staff did assessments of the residents at the time and notified the families of each of the residents. The DOC indicated that she notified the pharmacy of the errors and that each of the resident's personal physicians were notified the next time they came in to see the resident.

During an interview with Inspector #641 on October 27, 2017, the Administrator #104 (ADM) indicated that the contract the licensee had with the staffing agency provider, specified that before a staff could work at Regency Manor, they were required to have eight hours of orientation in the home which would include education modules in Surge Learning. The ADM indicated that on a specified date, when the RN in charge was not able to fill the RPN shift for the next day, she would have called the agency to alert them that the home required an RPN for the day shift the next day. Because of the contract the licensee had with the staffing agency provider, the expectation was that the agency would only send someone who was qualified to work in the home, meaning the RPN would have already received the proper orientation required. The ADM indicated that the RN who requested the RPN from the agency would not be aware of which of the agency's staff had received the proper training and orientation to be able to work at Regency Manor.

Inspector #641 interviewed the Managing Director of the staffing agency provider (MD) #105 on October 27, 2017. The MD #105 indicated that on the specified date, the agency didn't have any of their usual staff who had already been orientated to the home available. MD #105 indicated that the normal process as per their contract with the licensee, was that each of the staff would have an eight hour orientation in the home

prior to any shifts, but because RPN #101 indicated that he was comfortable going into the home with only two hours of orientation, she decided to send him. He was to arrive at 0500 for two hours of orientation and then begin his shift at 0700.
MD #105 indicated that RPN #101 was new to their agency and had not worked any shifts yet. He had graduated as an RPN in 2015, but had not worked as an RPN yet.
MD #105 indicated that RPN #101 had assured her that he had completed a three month clinical precept in Long Term Care during his nursing education and had given out medications during that time. Part of his orientation with the agency included the information that someone at the agency was on call 24/7 to assist them if they ran into any problems or needed assistance and also that they were to ask for assistance from the staff available in the home as well.
MD #105 indicated that currently RPN #101 was out of the country and could not be reached.

A compliance order is being issued due to the widespread scope and risk of actual harm to the residents and the homes non-compliance history related to medications not being given as prescribed.

The licensee failed to ensure that drugs were administered to 26 residents in accordance with the directions for use specified by the prescriber. Log #020906-17 [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 10th day of November, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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 Homes Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CATHI KERR (641)
Inspection No. / No de l'inspection :	2017_589641_0035
Log No. / No de registre :	020906-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 9, 2017
Licensee / Titulaire de permis :	CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP c/o Southbridge Care Homes, 766 Hespeler Road, Cambridge, ON N3H 5L8
LTC Home / Foyer de SLD :	REGENCY LONG TERM CARE HOME 66 DORSET STREET EAST, PORT HOPE, ON, L1A-1E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Gallant

To PROVINCIAL NURSING HOME LIMITED PARTNERSHIP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee shall:
a) Develop and implement a process to ensure that medications are administered to all residents in accordance with the directions for use, as specified by the prescriber, when a registered nurse or a registered practical nurse works at the home pursuant to a contract between the licensee and an employment agency.
b) Ensure that all registered nurses or registered practical nurses who work in the home pursuant to a contract between the licensee and an employment agency attend the planned orientation period prior to working in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Director of Care (DOC) contacted the Ministry of Health and Long-Term Care's after hours pager on a specified date and subsequently submitted a Critical Incident Report (CIR) #2511-000005-17 to the Director regarding an incident in the home related to multiple residents not receiving their medication on that day.

On a specified date, the home was unable to fill the 0700 to 1500 RPN shift on Unit A, with their own staff and had contacted a staffing agency provider who supplied the home with RPN #101. At the end of the shift at 1500, the oncoming RN #103 was notified by RN #102, that RPN #101 had not given medications to a large number of residents. RN #103 notified the Director of Care (DOC) and initiated medication incidents for all of the residents who had not received their medications.

Inspector #641 interviewed RN #102 on October 25, 2017. RN #102 indicated that on a specified date, she was working on the first floor which had 20 residents and RPN #101 was working on the second floor, Unit A, which had 40 residents. RN #102 indicated that she went up to the second floor after 0900 hours and RPN #101 indicated to her at the time that he was a little behind with administering the resident's medications because he didn't know the residents. RN #102 wasn't concerned at that point because he was new. RN #102 signified that RPN #101 did not ask for help or suggest that he was overwhelmed at that time.

RN #102 signified that she was back on the second floor before lunch to do treatments on the unit and RPN #101 hadn't indicated to her that he was behind with administering the resident's medications. RN #102 acknowledged that sometime between 1230 and 1300, RN #102 went upstairs and assessed the situation and realized only 8-9 residents had received their medications at that point. RN #102 indicated that the oncoming RN #103 arrived about 1440 and she informed RN #103 about the medications not being given on the second floor. RN #102 indicated that RN #103 took over at this point and notified the DOC and initiated the incident reports.

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Inspector #641 reviewed the e-MAR (electronic Medication administration record) and a paper copy of the e-MARs, for the residents on Unit A for the 0700 to 1500 shift on a specified date. There were 26 residents identified who had not received some or all of their medications during that shift. The agency RPN did not have computer access so he had documented his medication pass on a

paper copy of the eMAR. For the following 26 residents, there was no documentation that RPN #101 had given some or all of their medications:

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The DOC indicated that the doctor on call for the home had been contacted and he indicated that he was not concerned about most of the medications that hadn't been given, but to give one specific medication, to resident #014.
DOC #100 indicated that the staff did assessments of the residents at the time and notified the families of each of the residents. The DOC indicated that she notified the pharmacy of the errors and that each of the resident's personal physicians were notified the next time they came in to see the resident.

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process as per their contract with the licensee, was that each of the staff would have an eight hour orientation in the home prior to any shifts, but because RPN #101 indicated that he was comfortable going into the home with only two hours of orientation, she decided to send him. He was to arrive at 0500 for two hours of orientation and then begin his shift at 0700.
MD #105 indicated that RPN #101 was new to their agency and had not worked any shifts yet. He had graduated as an RPN in 2015, but had not worked as an RPN yet. MD #105 indicated that RPN #101 had assured her that he had completed a three month clinical precept in Long Term Care during his nursing education and had given out medications during that time. Part of his orientation with the agency included the information that someone at the agency was on call 24/7 to assist them if they ran into any problems or needed assistance and also that they were to ask for assistance from the staff available in the home as well.

MD #105 indicated that currently RPN #101 was out of the country and could not be reached.

A compliance order is being issued due to the widespread scope and risk of actual harm to the residents and the homes non-compliance history related to medications not being given as prescribed.

The licensee failed to ensure that drugs were administered to 26 residents in accordance with the directions for use specified by the prescriber. Log #020906-17 [s. 131. (2)] (641)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 01, 2017

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 Health and 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et 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 9th day of November, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Cathi Kerr

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