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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159 Cedar Street Suite 403
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 28, 2019	2019_771734_0002 (A1)	022009-18, 025983-18, 026091-18, 000020-19, 000740-19	Critical Incident System

Licensee/Titulaire de permis

Barrie Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

Amended by JADY NUGENT (734) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Requested and approved compliance due date extension for CO #002 and CO #003 to April 15, 2019.

Issued on this 28th day of March, 2019 (A1)

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

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*

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Roberta Place
503 Essa Road BARRIE ON L4N 9E4

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

Amended by JADY NUGENT (734) - (A1)

Amended 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): February 11-15 and February 19-20, 2019.

The following intakes were inspected upon during this Critical Incident System Inspection:

-one related to a fracture;

-one related to a resident elopement;

-one related to staff to resident neglect;

-one related to resident to resident abuse and

-one related to a medication incident.

A Follow-up inspection #2019_771734_0004 and Complaint inspection #2019_771734_0003 were conducted concurrently with this Critical Incident System (CIS) inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Director of Care (Co-DOC), Restorative Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of the original inspection, Non-Compliances were issued.
- **6 WN(s)**
- **3 VPC(s)**
- **3 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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The licensee submitted a Critical Incident System (CIS) report to the Director for an incident that caused injury to a resident for which the resident was taken to hospital. A review of the CIS report by Inspector #734 indicated that resident #001 sustained an injury while they were being transferred by Personal Support Worker (PSW) #100.

Inspector #734 conducted a review of resident #001's health care records. A progress note dated on the day of the incident described what had transpired resulting in the injury. An imaging report received five days later after the initial incident confirmed that resident #001 had sustained a fracture to an area of their body.

During an interview with Inspector #734, PSW #100 denied that they were involved in resident #001 having sustained an injury.

A review of the licensee's policy titled, "Resident Transfers, Lifts and Positioning Guidelines", last revised April 2018, indicated that staff were to ensure that equipment required was available and in proper position and locked for resident transfer.

In an interview with Registered Practical Nurse (RPN) #106, they indicated that PSW #100 had reported to them that while transporting resident #001 they sustained an injury involving their mobility aid.

In an interview with PSW #107, they indicated that during transport, resident #001 required a specific intervention for safe transfers, as the resident was at risk for possible injury.

A review of resident #001's care plan at the time of the incident by Inspector #734 identified an intervention that confirmed the required use of their mobility aid.

In a review of the home's internal investigation notes, which included a letter to PSW #100, the outcome of the investigation determined that PSW #100 had transferred resident #001 incorrectly.

During an interview with Director of Care (DOC) #102 they confirmed that a letter was issued to, and signed by PSW #100. In this letter it described what occurred between the PSW and the resident and stated that an, "unacceptable action took place". The DOC explained that unacceptable action meant anything that went against the home's policies or the Long-Term Care Homes Act. They also confirmed that it was determined during the investigation that PSW #100 did not transport resident #001 correctly. [s. 36.]

Additional Required Actions:

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

WN #2: 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).

s. 131 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

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.

A CIS report was submitted to the Director for a medication incident that affected resident #006's health status and resulted in hospitalization. The report identified that resident #006 was administered an incorrect dose of medicine, instead of the ordered dose. Specifically, it was discovered that nursing student #123, had provided an incorrect amount of medication to resident #006, but it was unknown how much was received.

Inspector #196 reviewed the health care records for resident #006. The physician's order that was current at the time of the medication incident read as an increase in the dosage amount.

Inspector #196 reviewed the home's policy titled, "Resident Rights, Care and Services - Medication Management - Administration of Medications", last revised

July 20, 2017, which indicated, "Apply the "rights" of medication administration, including the right dose".

During an interview with the DOC, they confirmed to the Inspector, that the incorrect dose of medication had been administered to resident #006. [s. 131. (2)]

2. The licensee failed to ensure that, a member of the registered nursing staff may permit a nursing student to administer drugs to residents if, (d) the nursing student who administered the drugs did so under the supervision of the member of the registered nursing staff.

A CIS report was submitted to the Director for a medication incident that affected resident #006's health status and resulted in hospitalization. Please see WN#2, finding #1, for additional information.

During an interview with Inspector #196, RPN #124 reported that nursing student #123 had been at the home for a specific period of time prior to the medication incident. They reported that they could not recall being informed that as a registered staff they had to be present with the student for all of the medication rights and stated, “once you are comfortable with the student and how they do the medications, you give them a bit of space”.

During an interview with the DOC, they reported that the expectation was that the registered nursing staff were to provide direct supervision of nursing students administering medications to residents. They also reported that a review was conducted on the date of the incident which indicated that the nursing student was not always supervised when administering medications and that the RPN was not present at the time of preparing the medication or the administration.

The DOC further added that as a nursing student they are working under the registration of the nurse; they are to be in tandem doing the medication rights together; checking the electronic medication administration record (e-mar) together, resident identification checks, medication package checks, ensure the right dose and the right medication. [s. 131. (4.1) (d)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002,003

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted to the Director for an incident that caused injury to a resident for which the resident was taken to hospital. According to the report, resident #004 had experienced a sustained injury.

During an interview with PSW #103, they indicated to Inspector #734 that resident #004 would still use their previously implemented mobility aid to ambulate around the unit. At the time of the incident resident #004 had used their previously implemented mobility aid intervention instead of the new mobility intervention listed in their current plan of care. PSW #103 also stated that on the day of the incident, they were one of the PSWs who assisted resident #004 using their previously retired mobility aid.

Inspector #734 conducted a review of resident #004's health care records. A progress note dated on the day of the incident indicated that resident #004 had sustained an injury in a specific area of the home. The care plan in effect at the time of the fall, under the mobility interventions section, identified that resident #004 used the new current mobility aid.

During an interview with RPN #104, they indicated that resident #004 utilized their previously implemented mobility aid on the day of the incident, and confirmed that they should not have been using this aid.

Further to this, in an interview with Restorative Coordinator #109, Inspector #734 reviewed the care plan intervention that indicated the use of a new mobility aid as resident #004's only mobility intervention. Restorative Coordinator #109 confirmed that the previous intervention of the use of another mobility aid had been retired, and based on the new intervention the mobility aid had been changed. Restorative Coordinator #109 acknowledged that they were aware that resident #004's still used their previously implemented mobility aid periodically. [s. 6. (7)]

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 that ensures the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: 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 that promotes zero tolerance of abuse and neglect of residents was complied with.

According to O. Reg 79/10, s.5 neglect is described as a failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The licensee submitted a CIS report to the Director. The report described how resident #010, #011, #012, #013, #014 and #015, had been neglected, which resulted in specific residents' care not being completed.

Inspector #734 reviewed the licensee's policy titled, "Resident Rights, Care and Services – Abuse – Zero Tolerance Policy for Resident Abuse and Neglect – Zero Tolerance Policy for Resident Abuse and Neglect", dated June 2017. The policy indicated that "zero tolerance" meant that Jarlette Health Services shall: uphold the right of the residents of long-term care facilities to be treated with dignity and respect within those facilities, and to live free from abuse and neglect". Furthermore they, "prohibit the abuse of any resident in Jarlette Health Services by any person, and prohibit the neglect of residents by staff".

During an interview with Registered Nurse (RN) #117, they confirmed that six residents were found by the PSWs in a specified home area. They reported to Inspector #734 that the PSWs informed them that residents were found in a state that would indicate that care was not completed during the previous shift.

During an interview with DOC #102, they confirmed that the home's investigation identified that PSW #120 had failed to provide care for residents' #014 and #015. Furthermore, the DOC also confirmed that the policy of Zero Tolerance – Resident Abuse and Neglect was the policy in place at that time of the incident. Based upon this policy it was confirmed that that PSW #120 did violate the home's policy as they failed to provide care to two residents. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures the written policy to promote zero tolerance of abuse and neglect is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures and interventions had been implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours and to minimize the risk of altercations and potentially harmful interactions between and among residents.

A CIS report was submitted to the Director in response to resident #002 exhibiting responsive behaviours towards resident #007.

A review, by Inspector #734 of resident #002's health care record, indicated that they had exhibited responsive behaviours prior to the incident. The progress notes indicated that the interventions that were implemented included specific monitoring and charting. Based on the charting records, resident #002 was to be checked and scored with a corresponding number based on behaviour at specific intervals. A record review of resident #002's progress notes indicated that they were to have charting completed beginning in a specified month.

A review of resident #002's chart for a specified period of time identified there was no documented charting on certain dates.

In an interview with RPN #113, they verified that resident #002's charting was to be included in their physical chart located at the nursing station. RPN #113 also confirmed that there were no further charting sheets present for resident #002 other than one sheet.

Inspector #734 asked Co-Director of Care #108 (Co-DOC) to locate the missing charting documents for resident #002. Co-DOC #108 confirmed that they were unable to locate any further chart documents for resident #002.

During an interview with DOC #102, they confirmed that the expectation was for staff to monitor resident #002 when they were placed on charting. Inspector #734 confirmed with DOC #102 that missed documentation meant the charting was not completed, and that blank spaces on the visible chart meant the behaviours were not documented. Based on the missing information, the DOC #102 stated, "We wouldn't be able to establish an accurate pattern of the resident's behaviours. We wouldn't be able to capture the whole picture." [s. 54. (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 that ensures procedures and interventions are implemented to assist residents and staff who are at risk of harm or who were harmed as a result of a resident's behaviours; and to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 5. A medication incident or adverse drug reaction in respect of which a resident was taken to hospital.

A CIS report was submitted to the Director for a medication incident that affected resident #006's health status and resulted in hospitalization. Please see WN#2, finding #1, for additional information.

A review of the licensee's policy titled, "Resident Rights, Care and Services - Reporting and Complaints - Critical Incident Reporting" last revised July 23, 2018, indicated, "The Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident through the CIS at ltchomes.net, followed by the written report required - A medication incident or adverse drug reaction in respect of which a resident is taken to hospital".

During an interview with the DOC, the reported that a CIS report was not submitted at the time of the medication incident as it had been missed in error. [s. 107. (3) 5.]

Issued on this 28th day of March, 2019 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JADY NUGENT (734) - (A1)
Inspection No. / No de l'inspection :	2019_771734_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	022009-18, 025983-18, 026091-18, 000020-19, 000740-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 28, 2019(A1)
Licensee / Titulaire de permis :	Barrie Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Roberta Place 503 Essa Road, BARRIE, ON, L4N-9E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Megan Merz

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

To Barrie Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, r. 36.

The licensee shall ensure that resident #001, and all other residents requiring transferring via mobility devices are done so in a safe manner.

Specifically the licensee must ensure that:
a) Resident #001 and all residents have clear directions in their plans of care regarding safe transferring requirements, where applicable, and
b) Staff are trained on safe transferring techniques; and maintain documentation of the education provided to staff, by whom, dates of the training and the content.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The licensee submitted a Critical Incident System (CIS) report to the Director for an incident that caused injury to a resident for which the resident was taken to hospital. A review of the CIS report by Inspector #734 indicated that resident #001 sustained an injury while they were being transferred by Personal Support Worker (PSW) #100.

Inspector #734 conducted a review of resident #001's health care records. A progress note dated on the day of the incident described what had transpired resulting in the injury. An imaging report received five days later after the initial incident confirmed that resident #001 had sustained a fracture to an area of their

body.

During an interview with Inspector #734, PSW #100 denied that they were involved in resident #001 having sustained an injury.

A review of the licensee's policy titled, "Resident Transfers, Lifts and Positioning Guidelines", last revised April 2018, indicated that staff were to ensure that equipment required was available and in proper position and locked for resident transfer.

In an interview with Registered Practical Nurse (RPN) #106, they indicated that PSW #100 had reported to them that while transporting resident #001 they sustained an injury involving their mobility aid.

In an interview with PSW #107, they indicated that during transport, resident #001 required a specific intervention for safe transfers, as the resident was at risk for possible injury.

A review of resident #001's care plan at the time of the incident by Inspector #734 identified an intervention that confirmed the required use of their mobility aid.

In a review of the home's internal investigation notes, which included a letter to PSW #100, the outcome of the investigation determined that PSW #100 had transferred resident #001 incorrectly.

During an interview with Director of Care (DOC) #102 they confirmed that a letter was issued to, and signed by PSW #100. In this letter it described what occurred between the PSW and the resident and stated that an, "unacceptable action took place". The DOC explained that unacceptable action meant anything that went against the home's policies or the Long-Term Care Homes Act. They also confirmed that it was determined during the investigation that PSW #100 did not transport resident #001 correctly.

The severity of this issue was determined to be a level 3, as there was actual harm to the resident. The scope of this issue was a level 1, as it was an isolated event. The home had a level 3 compliance history as they had a previous noncompliance with this section of the LTCHA that included:

-a Voluntary Plan of Correction (VPC) issued June 22, 2016 (2016-393606_0006);
-a VPC issued September 28, 2018 (2018_655679_0024). (734)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 26, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 002

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 must be compliant with O.Reg. 79/10, r. 131. (2)

The licensee shall ensure that drugs are administered to resident #006 and all other residents, in accordance with the directions for use specified by the prescriber.

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.

A CIS report was submitted to the Director for a medication incident that affected resident #006's health status and resulted in hospitalization. The report identified that resident #006 was administered an incorrect dose of medicine, instead of the ordered dose. Specifically, it was discovered that nursing student #123, had provided an incorrect amount of medication to resident #006, but it was unknown how much was received.

Inspector #196 reviewed the health care records for resident #006. The physician's order that was current at the time of the medication incident read as an increase in the dosage amount.

Inspector #196 reviewed the home's policy titled, "Resident Rights, Care and Services - Medication Management - Administration of Medications", last revised July 20, 2017, which indicated, "Apply the "rights" of medication administration, including the right dose".

During an interview with the DOC, they confirmed to the Inspector, that the incorrect dose of medication had been administered to resident #006.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of this issue was a level 1, as it was an isolated event. The home had a level 2 compliance history, with unrelated non-compliance having been issued in last 36 months. (734)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2019(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10,
s. 131 (4.1) A member of the registered nursing staff may permit a nursing student to administer drugs to residents if,
(a) the licensee has verified with the university or college that offers the nursing educational program in which the nursing student is enrolled that the nursing student has received education or training about the administration of drugs as part of the program;
(b) the nursing student has been trained by a member of the registered nursing staff in the written policies and protocols for the medication management system referred to in subsection 114 (2);
(c) the member of the registered nursing staff who is permitting the administration is satisfied that the nursing student can safely administer drugs; and
(d) the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, r. 131. (4.1.).

The licensee shall ensure a member of the registered nursing staff may permit a nursing student to administer drugs to residents, if the nursing student who administers the drugs does so under the supervision of the member of the registered nursing staff.

Grounds / Motifs :

1. The licensee failed to ensure that, a member of the registered nursing staff may permit a nursing student to administer drugs to residents if, (d) the nursing student who administered the drugs did so under the supervision of the member of the registered nursing staff.

A CIS report was submitted to the Director for a medication incident that affected resident #006's health status and resulted in hospitalization. Please see WN#2, finding #1, for additional information.

During an interview with Inspector #196, RPN #124 reported that nursing student #123 had been at the home for a specific period of time prior to the medication incident. They reported that they could not recall being informed that as a registered staff they had to be present with the student for all of the medication rights and stated, "once you are comfortable with the student and how they do the medications, you give them a bit of space".

During an interview with the DOC, they reported that the expectation was that the registered nursing staff were to provide direct supervision of nursing students administering medications to residents. They also reported that a review was conducted on the date of the incident which indicated that the nursing student was not always supervised when administering medications and that the RPN was not present at the time of preparing the medication or the administration.

The DOC further added that as a nursing student they are working under the registration of the nurse; they are to be in tandem doing the medication rights together; checking the electronic medication administration record (e-mar) together, resident identification checks, medication package checks, ensure the right dose and the right medication.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the resident. The scope of this issue was a level 1, as it was an isolated event. The home had a level 2 compliance history, with unrelated non-compliance having been issued in last 36 months. (734)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2019(A1)

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

Ministère 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

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:

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

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 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)
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 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 28th day of March, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JADY NUGENT (734) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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