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
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jul 28, 2017	2017_640601_0016	013742-17	Complaint

Licensee/Titulaire de permis

CVH (No.6) GP Inc. as general partner of CVH (No.6) LP
c/o Southbridge Care Homes Inc. 766 Hespeler Road, Suite 301 CAMBRIDGE ON N3H 5L8

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

Port Perry Place
15941 Simcoe Street Port Perry ON L9L 1N5

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 6, 7, 11 and 12, 2017.

Log #013742-17 regarding allegations of resident neglect.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care (ADOC), the Physician, Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Nutritional Care Manager (NCM), Personal Support Workers (PSW) and residents.

The inspector also toured one home area, observed interaction between staff and residents, administration of medication, reviewed resident clinical health records and applicable policies of the licensee.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 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. 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 the licensee's policy related to medication administration and transcribing of physician's orders was complied with to ensure safe, effective administration of medication for resident #001.

O. Reg. 79/10, 114. (2) 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, destruction and disposal of all drugs used in the home.

The licensee's "Medication Management" policy #RC-06-05-07 was reviewed by Inspector #601 and directed:
Scheduled medication will be administered according to standard medication administration times. Medications should be given within the recommended time frame, sixty minutes prior to and sixty minutes after the scheduled administration time.
All medication administered, refused or omitted will be documented immediately after administration on the Medication Administration Record (MAR), Electronic Medication Administration Record (eMAR) and Treatment Administration Record (TAR), Electronic Treatment Administration Record (eTAR) using the proper codes by the administrating nurse.

The licensee's "Ordering Medication Using the Physician's ePen Order Form" Policies and Procedures Long-term Care (section four, page Forty-three) regarding "Processing Physician's Orders: Medication changes and Discontinuations" directed: Orders will be transcribed to current MAR sheets by the facility or eMAR by pharmacy during regular hours or by the facility after hours.

During the course of the inspection, Inspector #601 reviewed a two week time period of resident #001's medication administration record.
It was identified that resident #001 had medication that had been ordered by the physician to be administered at 0800 hours.

Inspector #601 reviewed resident #001's "Medication Admin Audit Report" for the same identified time period and identified that all of resident #001's 0800 hour medications were administered greater than one hour following the administration scheduled time on five identified dates and times.

In a telephone interview with RPN #105 indicated to Inspector #601 that resident #001 often refuses medication and several attempts were required. RPN #105 also indicated that she/he would sign the eMAR at the time resident #001 received the medication.

During an interview, the Pharmacist indicated to Inspector #601 that resident #001's medication should be given according to the licensee's policy for medication administration, the physician's orders and the medication administration times as indicated on the eMAR.

2. Review of resident#001's physician orders by Inspector #601 identified that resident #001's physician had ordered a decrease in administration time for a specific medication.

During an interview, RPN Student #112 indicated to Inspector #601 that resident #001's eMAR had prompted her/him to give resident #001 the specified medication as the physician had previously ordered.

RPN Student #112 indicated resident #001 received the specified medication because she/he was not aware that the medication time had been changed the day prior.

In a telephone interview, RPN #105 indicated to Inspector #601 that resident #001's condition had declined. RPN #105 also indicated that she/he contacted the physician to advise of the change in resident' #001's condition.

RPN #105 indicated the physician ordered a decrease in the administration time for resident #001's specified medication.

RPN #105 indicated that she/he could not recall transcribing the changes in resident #001's physician order into the resident's eMAR.

RPN #105 indicated the eMAR would have prompted the nurse to give the medication if the order had not been transcribed into the resident's eMAR.

During an interview, the Pharmacist indicated to Inspector #601 that resident #001's physician's order should have been transcribed as per the licensee's policy related transcribing physician's orders outside regular business hours. [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 the licensee's policy related to medication administration and transcribing of physician's orders, including any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

Issued on this 28th day of July, 2017

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

Original report signed by the inspector.