Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Dec 23, 2019	2019_607523_0054	023012-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the County of Lambton
789 Broadway Street WYOMING ON N0N 1T0

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

Marshall Gowland Manor
749 Devine Street SARNIA ON N7T 1X3

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

ALI NASSER (523)

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): December 4, 5, 6 and 13 2019.

This inspection was completed for Critical Incident Intake Log #023012-19, CIS #M613-000041-19, related to unlawful conduct that resulted in harm or risk of harm residents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Pharmacist, Constable, Clerk, three Registered Staff members, one Personal Support Worker, and a resident.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Medication

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **1 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 LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be protected from abuse was fully respected and promoted.

The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on certain dates where he provided direct care to the residents.

A review of the internal investigation notes showed that this person entered the home on a specific dates and introduced themselves as a nursing student, they provided direct care to the residents and they administered medications including controlled substances

to specific residents.

In an interview a specific RPN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RPN thought that they were Personal Support Worker (PSW) student, they provided direct care to specific residents, then this person told the RPN that they can assist with oral medications. On another date this person came to the same unit and the RPN allowed them to prepare and administer medications, including controlled substances to specific residents.

In an interview a specific RN said that on a certain a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RN allowed this person to prepare and administer medication including controlled substances to specific residents. The RN said that this person was left alone with a resident in their room for a brief period.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not an employee of the home nor a volunteer nor a family member walked into the home on specific dates. This person was permitted to provide direct care to residents, they prepared and administered medications including controlled substances to specific residents. The Administrator said that the residents were put at risk by allowing an intruder to deliver direct care to residents.

The Administrator said that they identified security gaps in their process and will be working on developing a new process to prevent similar incidents in the future.

2. The licensee has failed to ensure that the resident’s right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act was fully respected and promoted.

The home submitted a Critical Incident System (CIS) report on a specific date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing

student. This person provided direct care and administered medications to residents on specific dates.

A review of the internal investigation notes showed that this person administered medications including controlled substances to specific residents on certain dates.

In an interview a specific RPN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RPN said that this person used their access to the resident's clinical records, reviewed their Electronic Medication Administration Records (EMAR), prepared and administered their medications.

In an interview a specific RN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RN said that this person used their access to the resident's clinical records, reviewed their Electronic Medication Administration Records (EMAR), prepared and administered their medications.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not an employee of the home nor a volunteer nor a family member walked into the home on certain dates. This person was permitted to access, view resident's clinical records and their personal health information and provided direct care to specific residents including medication administration. The Administrator said that the residents were put at risk by allowing an intruder to deliver direct care to residents.

The Administrator said that they did not fully respected and promoted the resident's right to protect their personal health information.

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 (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 :

The licensee has failed to ensure that 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).

The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on specific dates. This person provided direct care and administered medications to residents.

A review of the internal investigation notes showed that a person entered the home on specific dates, this person identified themselves as a nursing student and the nursing staff allowed them to prepare and administer medications including controlled

substances to specific residents.

In an interview a specific RPN said that on certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student and informed them that they could administer oral medication. On another date the RPN allowed the intruder to prepare and administer medications for specific residents. The RPN said in an interview that they did not verify or receive any verification or information from the home that this person was actually a nursing student or if they were qualified or if they received education or training about the administration of drugs as part of their nursing program. The RPN also said that they did not provide any training to the nursing student in the home's written policies and protocols for the medication management system.

In an interview the DOC said that before having the nursing students in the home they did not receive any information to verify that the nursing student had received education or training about the administration of drugs as part of their program. The DOC said that they were not aware that the nursing student had to be trained by the nursing staff in the written policies and protocols for the medication management system before they can administer medications in the home.

In an interview the Administrator said that they had identified some gaps in their process for precepting students in the home. The Administrator was going to review the process to prevent similar incidents in the home.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

The licensee to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home.

The home submitted a Critical Incident System (CIS) report on a specific date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on specific dates. This person provided direct care and administered medications to residents on certain dates.

A review of the internal investigation notes showed that this person entered the home on certain dates, provided direct care and administered medications including controlled substances to specific residents.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not able to dispense, prescribe or administer drugs in the home had walked into the home and was permitted to provide direct care to residents, they had access to the drug storage, prepared and administered drugs including controlled substances to specific residents.

Additional Required Actions:

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

WN #4: 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 plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with all applicable requirements under the Act.

The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student. This person provided direct care and administered medications to residents on certain dates.

ONTARIO REGULATION 79/10, section 114 (2) stated "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. O. Reg. 79/10, s. 114 (2)".

ONTARIO REGULATION 79/10, section 131 (4.1) stated "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."

In an interview the DOC said that they were not aware of any policy in their medication administration management system informing them that the nursing student had to be trained by the nursing staff in the written policies and protocols for the medication management system before they can administer medications in the home.

In an interview the Pharmacist said that they were not aware of any procedure in their policy manual that would be in compliance with this specific regulation.

In an interview the Administrator said that they would work with pharmacy to ensure that the policy was in compliance with the regulation.

2. 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 plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, was complied with.

The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student. This person provided direct care and administered medications to residents on specific dates.

ONTARIO REGULATION 79/10, section 114 (2) stated “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. O. Reg. 79/10, s. 114 (2)".

A review of the home's Medication Administration and Documentation, Medication Administration and Documentation Overview. Policy No. 4.1 revised August 15, 2018, showed that all medication administration must be documented on the Medication Administration Record at the point of administration by the registered staff administering the medication.

In an interview a specific RPN said that they allowed a nursing student to administer medications on a specific date using their log in to the EMAR. The RPN said that their signature was on the EMAR but they did not administer the medication.

In an interview a specific RN said that they allowed a nursing student to administer medications on a specific date using their log in to the EMAR. The RN said that their signature was on the EMAR but they did not administer the medication.

In an interview the DOC said that the staff did not comply with the home's policy.

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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system, was in compliance with all applicable requirements under the Act., and was complied with, to be implemented voluntarily.

Issued on this 30th day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523)
Inspection No. / No de l'inspection :	2019_607523_0054
Log No. / No de registre :	023012-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 23, 2019
Licensee / Titulaire de permis :	The Corporation of the County of Lambton 789 Broadway Street, WYOMING, ON, N0N-1T0
LTC Home / Foyer de SLD :	Marshall Gowland Manor 749 Devine Street, SARNIA, ON, N7T-1X3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carla Alway

To The Corporation of the County of Lambton, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee must be compliant with s. 3 (1) of the LTCHA.

Specifically, the licensee must:
a) Develop a system for sign in or check in with the management team for all volunteers, students, instructors of colleges, universities and other support providers when entering the home.
b) Ensure all volunteers, students, instructors of colleges, universities and other support providers have proper identification when present in the home.
c) Ensure that resident's are protected from abuse and the home is a safe environment by not allowing intruders into the home and by ensuring that only staff of the home provide direct care to the residents.
d) Ensure that resident's personal health information are kept confidential and only authorized personal will have access to the resident's information.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident's right to be protected from abuse was fully respected and promoted.

The home submitted a Critical Incident System (CIS) report on a certain date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm

or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on certain dates where he provided direct care to the residents.

A review of the internal investigation notes showed that this person entered the home on a specific dates and introduced themselves as a nursing student, they provided direct care to the residents and they administered medications including controlled substances to specific residents.

In an interview a specific RPN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RPN thought that they were Personal Support Worker (PSW) student, they provided direct care to specific residents, then this person told the RPN that they can assist with oral medications. On another date this person came to the same unit and the RPN allowed them to prepare and administer medications, including controlled substances to specific residents.

In an interview a specific RN said that on a certain a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RN allowed this person to prepare and administer medication including controlled substances to specific residents. The RN said that this person was left alone with a resident in their room for a brief period.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not an employee of the home nor a volunteer nor a family member walked into the home on specific dates. This person was permitted to provide direct care to residents, they prepared and administered medications including controlled substances to specific residents. The Administrator said that the residents were put at risk by allowing an intruder to deliver direct care to residents.

The Administrator said that they identified security gaps in their process and will be working on developing a new process to prevent similar incidents in the future. (523)

2. The licensee has failed to ensure that the resident's right to have his or her

personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act was fully respected and promoted.

The home submitted a Critical Incident System (CIS) report on a specific date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student. This person provided direct care and administered medications to residents on specific dates.

A review of the internal investigation notes showed that this person administered medications including controlled substances to specific residents on certain dates.

In an interview a specific RPN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RPN said that this person used their access to the resident's clinical records, reviewed their Electronic Medication Administration Records (EMAR), prepared and administered their medications.

In an interview a specific RN said that on a certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student. The RN said that this person used their access to the resident's clinical records, reviewed their Electronic Medication Administration Records (EMAR), prepared and administered their medications.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not an employee of the home nor a volunteer nor a family member walked into the home on certain dates. This person was permitted to access, view resident's clinical records and their personal health information and provided direct care to specific residents including medication administration. The Administrator said that the residents were put at risk by allowing an intruder to deliver direct care to

residents.

The Administrator said that they did not fully respected and promoted the resident's right to protect their personal health information. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 30, 2019

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre : 002

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 r. 131 (4.1) of the Ontario Regulation 79/10

Specifically, the licensee must:
a) Develop a documented process in the home for precepting students that includes but not limited to:
i) Ensure the home had verified that the nursing student has received education or training about the administration of drugs as part of their program.
ii) Ensure 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).
iii) Ensure all students have received the mandatory training required before providing direct care to the residents. This training to be provided by the home.
iv) Ensure that the home's staff received proper communication with the names of the students prior to having the students.
v) Ensure that the home's staff are aware of this process.
vi) Ensure a record of the process and the training for students are kept in the home.

b) Ensure that the medication administration system would be in compliance with r 131(4.1).

c) Ensure that the home's medication administration policy is complied with by ensuring that medication administration is documented by the registered staff who administer the medication.

Grounds / Motifs :

1. The licensee has failed to ensure that 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).

The home submitted a Critical Incident System (CIS) report on a certain date to

the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on specific dates. This person provided direct care and administered medications to residents.

A review of the internal investigation notes showed that a person entered the home on specific dates, this person identified themselves as a nursing student and the nursing staff allowed them to prepare and administer medications including controlled substances to specific residents.

In an interview a specific RPN said that on certain date a person walked into the resident home area wearing scrubs and identified themselves as a nursing student and informed them that they could administer oral medication. On another date the RPN allowed the intruder to prepare and administer medications for specific residents. The RPN said in an interview that they did not verify or receive any verification or information from the home that this person was actually a nursing student or if they were qualified or if they received education or training about the administration of drugs as part of their nursing program. The RPN also said that they did not provide any training to the nursing student in the home's written policies and protocols for the medication management system.

In an interview the DOC said that before having the nursing students in the home they did not receive any information to verify that the nursing student had received education or training about the administration of drugs as part of their program. The DOC said that they were not aware that the nursing student had to be trained by the nursing staff in the written policies and protocols for the medication management system before they can administer medications in the home.

In an interview the Administrator said that they had identified some gaps in their process for precepting students in the home. The Administrator was going to review the process to prevent similar incidents in the home. (523)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 30, 2019

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

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 # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 130. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Order / Ordre :

The licensee must be compliant with r. 130 (2) (i) of the Ontario Regulation 79/10

Specifically, the licensee must:
a) Ensure that access to all areas where drugs are stored shall be restricted to persons who may dispense, prescribe or administer drugs in the home.

Grounds / Motifs :

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

1. The licensee to ensure that all areas where drugs were stored were restricted to persons who may dispense, prescribe or administer drugs in the home.

The home submitted a Critical Incident System (CIS) report on a specific date to the Ministry of Long-Term Care related to unlawful conduct that resulted in harm or risk of harm to residents.

The CIS showed that a person walked into the home and pretended to be a nursing student on specific dates. This person provided direct care and administered medications to residents on certain dates.

A review of the internal investigation notes showed that this person entered the home on certain dates, provided direct care and administered medications including controlled substances to specific residents.

In an Interview the Administrator said that they reviewed video surveillance from the residents' home area and confirmed that a person who was not able to dispense, prescribe or administer drugs in the home had walked into the home and was permitted to provide direct care to residents, they had access to the drug storage, prepared and administered drugs including controlled substances to specific residents. (523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 30, 2019

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 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
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 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 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 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 23rd day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ali Nasser

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