Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Sep 25, 26, 27, 2012	2012_035124_0026	Follow up

Licensee/Titulaire de permis

SPECIALTY CARE EAST INC.
400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3

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

TRILLIUM CENTRE
800 EDGAR STREET, KINGSTON, ON, K7M-8S4

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

LYNDA HAMILTON (124)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Directors of Care, Nursing Projects Co-ordinator, Registered Nurse, Registered Practical Nurses, Recreation Co-ordinator and the Recreation Aid.

During the course of the inspection, the inspector(s) reviewed resident health care records including electronic Medication Administration Records, observed medication administration and inspected seven medication carts.

The following Inspection Protocols were used during this inspection:

Medication

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 114. Medication management system

Specifically failed to comply with the following subsections:

s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. 79/10 s. 114 (1) in that the licensee of a long-term care home does not have an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
A Compliance Order was issued on June 25, 2012 related to O. Reg. 79/10 s.114 (1). During the follow up inspection, four areas of non-compliance related to the medication management system received written notifications:
WN #3- O. Reg. 131 (1)
Resident #8 had a bottle of medication, with the direction to administer daily, in his medication slot. Six tablets of this medication were dispensed by Picton Pharmacy on September 20, 2012 and arrived at the home that evening. On September 26, 2012, there were two tablets of this medication remaining in the bottle. There was no clinical documentation to explain why Resident #8 did not receive two doses of this medication between September 21-26, 2012.
Resident #9 was prescribed a two tablets of a specific medication by mouth daily. On September 20, 2012, twelve tablets of this specific medication were dispensed by Picton Pharmacy and arrived at the home that evening. On September 26, 2012, there are seven tablets remaining in the bottle. S#104 reported that registered staff was using one tablet from the resident's strip package and one from the bottle. This would indicate that Resident #9 received one incorrect dose of this medication between September 21-26, 2012.
S104 confirmed that these two residents did not receive medication in accordance with the directions for use specified by the prescriber.

WN #2- O.Reg. 129 (1)(b)
On September 5, 2012 on or about 15:28 hours, two vials of injectable medication for Resident # 6 and four vials of injectable medication for Resident #7 were observed inside a clear, unlocked plastic box in the refrigerator located in the Garden House medication room. The vials of injectable medication were not stored in a separate, double-locked stationary cupboard in the locked area.

WN #3- O.Reg. 131 (3)
On September 25, 2012, the inspector observed S#102 request and receive medications for Residents #10 and #11 who were attending an off-site activity.
S#102 provided the medication to S#103 on September 25, 2012 because S#103 was accompanying the residents to the activity.
On September 26, 2012, S#103 reported to the inspector that she administered the provided medication to Residents #10 and #11.
S#103 is not a physician, a dentist, a registered nurse or a registered practical nurse.

WN #2- O. Reg. 129 (1) (a) (i)
On September 25, 2012 the following was observed:
-in Resident #1's medication slot there was a small black container for hearing aid batteries
-a black eye glass holder with eye glasses inside in Resident #2's medication slot
-a small change purse with pennies and a broach inside in the fifth drawer of the Garden House medication cart where the as needed medication and stock medication was stored
-treatment devices in Resident #3's medication slot in the second drawer of the Cottage House medication cart where other residents' medications were stored
-in Resident #4's medication slot was an insurance card and the resident's health card
-Resident #5's health card was stored with the resident's medications in the medication slot.

Additional Required Actions:

CO # - 901 was 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. 129. Safe storage of drugs

Specifically failed to comply with the following subsections:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 129 (1) (b) related to the storage of controlled substances.

On September 5, 2012 on or about 15:28 hours, two vials of injectable medication for Resident # 6 and four vials of injectable medication for Resident #7 were observed inside a clear, unlocked plastic box in the refrigerator located in the Garden House medication room. The vials of injectable medication were not stored in a separate, double-locked stationary cupboard in the locked area.
2. The licensee failed to comply with O.Reg. 79/10 s. 129. (1)(a) in that drugs were not stored in an area or medication cart that is used exclusively for drugs and drug related supplies as demonstrated by the following findings.

On September 25, 2012 the following was observed:
-in Resident #1's medication slot there was a small black container for hearing aid batteries
-a black eye glass holder with eye glasses inside in Resident #2's medication slot
-a small change purse with pennies and a broach inside in the fifth drawer of the Garden House medication cart where the as needed medication and stock medication was stored
-two toe spacers in Resident #3's medication slot in the second drawer of the Cottage House medication cart where other residents' medications were stored
-in Resident #4's medication slot was an insurance card and the resident's health card
-Resident #5's health card was stored with the resident's medications in the medication slot.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following subsections:

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. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee failed to comply with O.Reg. s. 131. (3) in that a person who is not a physician, dentist, registered nurse or registered practical nurse administered medication to a resident.
On September 25, 2012, the inspector observed registered staff (S#100 and S#101) give S#102 medications for Residents #10 and #11 who were attending an off-site activity.
S#102 provided the medication to S#103 on September 25, 2012 because S#103 was accompanying the residents to the activity.
On September 26, 2012, S#103 reported to the inspector that she administered the provided medication to Residents #10 and #11.
S#103 is not a physician, a dentist, a registered nurse or a registered practical nurse.
2. The licensee failed to comply with O. Reg. 131. (2) related to the administration of medication.
Resident #8 had a bottle of medication with the direction to administer daily, in his medication slot. Six tablets of this medication were dispensed by Picton Pharmacy on September 20, 2012 and arrived at the home that evening. On September 26, 2012, there were two tablets of this medication remaining in the bottle. There was no clinical documentation to explain why Resident #8 did not receive two doses of this medication between September 21-26, 2012.
Resident #9 was prescribed a specific medication, two tablets by mouth daily. On September 20, 2012, twelve tablets of this medication were dispensed by Picton Pharmacy and arrived at the home that evening. On September 26, 2012, there are seven tablets of this medication remaining in the bottle. S#104 reported that registered staff was using one tablet from the resident's strip package and one from the bottle. This would indicate that Resident #9 received one incorrect dose of this medication between September 21-26, 2012.
S104 confirmed that these two residents did not receive medication in accordance with the directions for use specified by the prescriber.

Issued on this 27th day of September, 2012

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

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA HAMILTON (124)
Inspection No. / No de l'inspection :	2012_035124_0026
Type of Inspection / Genre d'inspection:	Follow up
Date of Inspection / Date de l'inspection :	Sep 25, 26, 27, 2012
Licensee / Titulaire de permis :	SPECIALTY CARE EAST INC. 400 Applewood Crescent, Suite110, VAUGHAN, ON, L4K-0C3
LTC Home / Foyer de SLD :	TRILLIUM CENTRE 800 EDGAR STREET, KINGSTON, ON, K7M-8S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JENNIFER POWLEY

To SPECIALTY CARE EAST 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

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 901

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

Linked to Existing Order / Lien vers ordre existant: 2012_035124_0018, CO #003

Pursuant to / Aux termes de :

O.Reg 79/10, s. 114. (1) Every licensee of a long-term care home shall develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. O. Reg. 79/10, s. 114 (1).

Order / Ordre :

The licensee shall ensure the home is providing an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents through compliance with:
-O.Reg. 131 (1) related to administration of medication as prescribed
-O.Reg. 131 (3) related to administration of medication by a physician, dentist, registered nurse or registered practical nurse
-O.Reg. 129 (1)(b) safe storage of controlled substances
-O. Reg 129 (1)(b) related ot storage area for medication that is exclusive for drugs and drug related supplies

Grounds / Motifs :

1. The licensee failed to comply with O.Reg. 79/10 s. 114 (1) in that the licensee of a long-term care home does not have an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents.
A Compliance Order was issued on June 25, 2012 related to O.Reg. 79/10, s. 114. (1). During the follow up inspection, four areas of non-compliance related to the medication management system received written notifications:
WN #3- O. Reg. 131 (1)
Resident #8 had a bottle of Eltroxin 0.1mg tablets, with the direction to administer daily, in his medication slot. Six Eltroxin 0.1mg tablets were dispensed by Picton Pharmacy on September 20, 2012 and arrived at the home that evening. On September 26, 2012, there were two Eltroxin 0.1mg tablets remaining in the bottle. There was no clinical documentation to explain why Resident #8 did not receive two doses of Eltroxin 0.1mg between September 21-26, 2012.
Resident #9 was prescribed Seroquel XR 50mg tablets, two tablets (100mg) by mouth daily. On September 20, 2012, twelve Seorquel XR 50 mg tablets were dispensed by Picton Pharmacy and arrived at the home that evening. On September 26, 2012, there are seven Seroquel XR 50mg tablets remaining in the bottle. S#104 reported that registered staff was using one Seroquel XR 50mg tablet from the resident's strip package and one from the bottle. This would indicate that Resident #9 received one 50 mg dose of Seroquel XR rather than the prescribed 100mg dose between September 21-26, 2012.
S104 confirmed that these two residents did not receive medication in accordance with the directions for use specified by the prescriber.

WN #2- O.Reg. 129 (1)(b)
On September 5, 2012 on or about 15:28 hours, two vials of injectable Lorazepam 4mg/ml for Resident # 6 and four vials of injectable Lorazepam 4mg/ml for Resident #7 were observed inside a clear, unlocked plastic box in the refrigerator located in the Garden House medication room. The vials of injectable Lorazepam were not stored in a separate, double-locked stationary cupboard in the locked area.

WN #3- O.Reg. 131 (3)
On September 25, 2012, the inspector observed registered staff (S$100 and S#101) provide S#102 with medications for Residents #10 and #11 who were attending an off-site activity.
S#102 provided the medication to S#103 on September 25, 2012 because S#103 was accompanying the residents to the activity.
On September 26, 2012, S#103 reported to the inspector that she administered the provided medication to Residents #10 and #11.
S#103 is not a physician, a dentist, a registered nurse or a registered practical nurse.

WN #2- O. Reg. 129 (1) (a) (i)
On September 25, 2012 the following was observed:
-in Resident #1's medication slot there was a small black container for her hearing aid batteries
-a black eye glass holder with eye glasses inside in Resident #2's medication slot
-a small change purse with pennies and a broach inside in the fifth drawer of the Garden House medication cart where the as needed medication and stock medication was stored
-two toe spacers in Resident #3's medication slot in the second drawer of the Cottage House medication cart where other residents' medications were stored
-in Resident #4's medication slot was an insurance card and the resident's health card
-Resident #5's health card was stored with the resident's medications in the medication slot. (124)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 26, 2012

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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 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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
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.

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 27th day of September, 2012

Signature of Inspector / Signature de l'inspecteur : L Hamilton

Name of Inspector / Nom de l'inspecteur : LYNDA HAMILTON

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