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
Feb 7, 2020	2020_573581_0002	000771-20	Complaint

Licensee/Titulaire de permis

Rykka Care Centres GP Inc.
3760 14th Avenue Suite 402 MARKHAM ON L3R 3T7

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

Arbour Creek Long-Term Care Centre
2717 King Street East HAMILTON ON L8G 1J3

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

DIANNE BARSEVICH (581)

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): January 29, 30, 31 and February 3, 2020.

The following intakes were inspected:
Complaint Inspection, log number 000771-20 related to medication administration, maintenance and housekeeping.

During the course of the inspection, the inspector(s) spoke with Executive Director (ED), Acting Director of Care (ADOC), Resident Assessment Instrument (RAI) Co-ordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Maintenance Staff, Personal Support Workers (PSW), family and residents.

During the course of the inspection, the inspector toured the home, reviewed the clinical records, observed medication pass, home areas, the provision of care and reviewed policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Medication
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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	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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

On an identified date in January 2020, it was identified that there was no Registered Nurse (RN) in the building on a specified shift.

Review of the staffing schedules identified that there were six shifts that an RN was not working in the home over a three month period in 2019 and 2020.

During an interview with the Executive Director (ED) and the Acting Director of Care (ADOC), they confirmed that for the identified shifts the home was not able to replace the RN, who was scheduled but could not attend work; and a Registered Practical Nurse (RPN) was called in to replace the RN. It was also reported that the home had all RN staffing lines filled; however, were actively trying to recruit additional RN staff to assist when the home could not replace the scheduled RN. [s. 8. (3)]

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 at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulation, to be implemented voluntarily.

WN #2: 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 failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy, was complied with.

In accordance with O. Reg. 79/10, s. 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, and destruction and disposal of all drugs used in the home.

The licensee's policy,Transcribing Physician's Orders or RN (EC)'s Orders, identified as index I.D: RCS F-65 and revised August 22, 2019, provided the following directions:
i. "Physician orders are transcribed in a timely and systematic manner to reduce potential errors."
ii. "The pharmacy will enter the orders in the PCC E-MAR. The registered staff will verify these orders for accuracy. The nurse should transcribe the orders as soon as they are entered by the pharmacy - generally on the following shift, but before the end of the shift (i.e. on the evening shift if the order received before 3 PM on the day shift.)
iii. "After transcription is complete, the nurse sign off order on Physician's Order Sheet. Indicating full signature, status, date and time that order was transcribed. Rule out remaining space so that additional orders may not be added on the remaining space.
iv. "Second check of transcribed order(s) will be completed by a different nurse on the same or the following shift. When the second registered staff (RN or RPN) has reviewed the order, they indicate this by "checked" and sign order including status.

The ED provided inspector a document from the Smart Med Pharmacist that outlined to registered staff the steps that needed to be performed when orders were transcribed and

processed. The Transcribing and Processing of Physician Orders provided the following directions:

i. "All physician orders whether on the regular physician order sheet or on the three months medication review and has been written by the physician or telephone orders; need to be signed off by two registered staff and the prescriber in a timely manner. Nurses must sign within 24 hours and the telephone orders by the prescriber signed during the next scheduled visit."

ii. "The nurse doing the first check on the order is responsible to make sure the drug is ordered from the pharmacy and is also responsible to make sure that the order correctly reflects on the E-MAR or E-TAR. This means the nurse would need to enter the order in the E-MAR if not yet done by the pharmacy in a timely manner."

iii. "Nursing staff should not wait for pharmacy to transcribe the orders especially in cases where they need to hold orders, discontinue orders, enter stat orders or administer drugs from stat box or satellite."

iv. "The first check of the order cannot be completed or signed off without making sure the order on the E-MAR or E-TAR is correctly entered with proper transcription as ordered by the prescriber and with proper start and stop dates."

v. "The second nursing check is an independent double check and it is usually performed by the next shift nurse who makes sure all the areas of the order are completed. The order must reflect correctly on the E-MAR/E-TAR by viewing the order as entered in the PCC and then check for accuracy in order transcription including start and stop dates. Finally, the nurse makes sure that if there is any task that is not completed for the order, view the right hand communication task column and make sure all the required tasks have been completed."

A. Review of the clinical record identified that resident #001 received an order on an identified date in April 2019, for a medication to be administered at an identified frequency, for a specified time period.

Following a review of the electronic medication administration record (eMAR) and clinical record with the Executive Director (ED), they verified that the order was not inputted into the eMAR by the pharmacy or registered staff for the identified time period and that the first check was signed on day shift that the medication was prescribed and the second

check was signed on the same day; however, during the night shift.

The ED confirmed that registered staff failed to comply with the licensee's policy, Transcribing Physician's Orders, when the medication was not documented in the eMAR for the specified time period and the second check for the prescribed medication was not completed on evening shift.

B. Review of the physician’s order for resident #001 included an order, on a specified date, in April 2019, for two medications to be administered at a specified frequency.

Review of eMAR identified that the medications were to be given twice a day, once on day shift and once on evening shift which was not consistent with the directions in the physician’s order.

During a review of the eMAR and clinical record with the ED, they verified that the first and second checks of the order were signed by two different registered staff; however, neither of them ensured that the order on the eMAR was correctly entered with proper transcription.

The ED confirmed that the licensee's policy, Transcribing Physician's Orders was not complied with.

C. Review of the clinical record identified that resident #001 received an order on an identified date in May 2019, for an identified medication to be administered at a specified frequency.

Review of the physician’s order form and eMAR did not include the order for the medication.

Following a review of the clinical record and eMAR with the ED, they confirmed the order was not transcribed onto the physician's order form by registered staff and the new order was not inputted into eMAR by registered staff.

The ED confirmed that the licensee's policy, Transcribing Physician's Orders was not complied with.

D. Resident #001 received an order for a medication on an identified date in May 2019, from an external practitioner.

Review of the physician's order form and eMAR with the ED, verified that the registered staff transcribed the order two days after the order was prescribed, did not document the time the order was written and the second check was not signed until the night shift, the day after the order was transcribed by the registered nursing staff.

The ED confirmed that the licensee's policy, Transcribing Physician's Orders was not complied with.

E. On a specified date in June 2019, resident #001 received an order from an external practitioner to discontinue a medication.

Review of the physician's order form did not identify that the order was transcribed to be discontinued.

Review of the June 2019, eMAR identified that the resident received the medication for an additional two days after it was discontinued.

In an interview with the ED, they stated that when the order was received, to discontinue the medication, the registered staff should have transcribed the order onto the physician's order sheet, contacted the most responsible physician (MRP) for confirmation of the order and inputted a stop date when the order was confirmed by the MRP.

The ED confirmed that the licensee's policy, Transcribing Physician's Orders was not complied with.

F. On a specified date in January 2020, the physician prescribed a treatment for resident #002 to be administered at an identified frequency.

Review of the physician's order form identified that the first check was signed off the following day; however, the time was not documented and the second check was signed off two days after the order was received.

Review of eMAR indicated that the medication was not administered to the resident for two days after the medication was ordered.

Following a review of the physician's order form and eMAR with the ED, they confirmed that registered staff should have completed the first check on the day the medication was

ordered and the second check either on the same shift or the next shift.

The ED confirmed that the licensee's policy,Transcribing Physician's Orders was not complied with. [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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy, was complied with, to be implemented voluntarily.

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:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On an identified date in June 2019, resident #001 received an order from an external practitioner to discontinue a medication.

Review of the clinical health record and eMAR with the ED identified that the MRP confirmed the order the same day; however, the eMAR identified that the resident

continued to receive the discontinued medication for an additional day.

The ED confirmed that the medication should have been discontinued when the home received the order from the MRP and the resident should not of received the medication after it was discontinued. [s. 131. (1)]

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

A. Review of the clinical record identified that resident #001 returned from an external service provider on an identified date in April 2019, with two medications and an order to administer the medications at a specified frequency.

A telephone order was received from the MRP and documented on the physician's order form by RPN #109 the following day, to administer the medications at a different frequency, when sleeping, and identified a date to stop the medications.

A review of the progress notes identified that the medications was administered as prescribed on specified dates/shifts, included shifts that the medications were refused by the resident; however, the eMAR did not include documentation that the resident was administered the medications during the time period.

Following a review of the eMAR and the physician’s orders, with RPN #109, they confirmed that the order was not inputted into the eMAR and therefore resident #001 did not receive the two medications as prescribed during the identified time period, other than on the identified shifts noted in the progress notes.

B. According to the clinical record, resident #001 went to an external appointment on an identified date in April 2019 and an order was given to registered staff for two medications to be administered at a prescribed frequency.

Registered staff documented in the progress notes that the medications were administered to the resident as ordered the day that the medications were ordered.

Review of the eMAR did not include documentation that the medications was administered as prescribed.

The eMAR and clinical record were reviewed by the Executive Director (ED) who verified

that the order from the appointment, was to administer the medications, both at a specified frequency.

The eMAR schedule directed registered staff to administer one medication at the prescribed frequency and the second medication at a different frequency than prescribed; however, the eMAR scheduled times only directed the registered staff to administer the medications at the different frequency than prescribed. The two medications were administered for 21 days as directed on the eMAR; however were not administered at the prescribed frequency.

The ED stated that the registered staff who received the order should have implemented each medication separately on the eMAR and inputted that the medications were to be administered and signed for at the prescribed frequency by registered staff as prescribed.

The ED confirmed the order for the two medications were not processed correctly and for this reason, resident #001's medications were not administered as prescribed.

C. Resident #001 received an order from an external practitioner on an identified date in May 2019, for a medication to be administered at an identified frequency with instructions "Do not to stop". A review of the May 2019, eMAR did not include that the medication was administered at the presribed frequency.

Following a review of the order with the ED, they verified that the order was not transcribed onto the physician's order, nor was the order implemented in the eMAR.

The ED confirmed that resident #001 did not receive the medication as prescribed.

D. A review of the clinical record identified on a specified date in May 2019, that resident #001 received an order from an external practitioner for a medication to be administered at a specified frequency. This was documented by RPN #106, two days later, on the physician's order form as a fax order from the MRP.

The eMAR and clinical record were reviewed with the ED who confirmed that the order was not processed in a timely manner as the resident was not administered the medication as prescribed until two days later.

Resident #001's medications were not administered as prescribed. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 13th day of February, 2020

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

Original report signed by the inspector.