Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 6, 2018	2018_520622_0008	005495-18	Resident Quality Inspection

Licensee/Titulaire de permis

2109577 Ontario Limited
195 Forum Drive Unit 617 MISSISSAUGA ON L4Z 3M5

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

Arbour Heights
564 Tanner Drive KINGSTON ON K7M 0C3

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

HEATH HEFFERNAN (622), AMBER LAM (541), JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): March 26, 27, 28, 29, 2018.

The following intakes were included as part of this inspection:
Log #005959-18, Log #005498-18 related to medication incidents with hospital transfer.
Log #029471-17 related to a fall with injury and transfer to hospital
Log #004760-18 related to a complaint to the home of alleged resident neglect.

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

Also during the course of the inspection, the inspectors conducted a tour of the home, observed resident care and services, medication administration and infection control practices, reviewed health records, the home's policies and procedures related to medication administration, skin and wound care program, skin integrity - skin assessment tool, human resource records, and the resident council minutes.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
1 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

Medication Incident #1 related to Critical Incident System report (CIS) #2981-000011-18 involved resident #022 who received medications that were not prescribed for them on a specified date and time. Resident #022 had multiple diagnoses. The CIS report indicated RPN #100 poured medications for another resident #029 however did not administer the medication to resident #029. RPN #100 approached resident #022 and administered resident #029's medications to them in error. As a result resident #022's condition changed, was given a prescribed treatment and transferred to hospital. Resident #022 returned to the nursing home with no lasting ill effect.

During an interview with inspector #622, the Director of Care #101 stated that resident #022 received resident #029's medication in error on a specified date.

Medication Incident #3 involved resident # 026 who received medications that were not prescribed for them on a specified date and time. Resident #026 had multiple diagnoses. A review of the medication incident documentation indicated on a specified date during a specified medication pass, RPN #100 administered resident #028's medications to resident #026 in error. As a result of the medication error, there was no ill effect noted to the resident.

During an interview with inspector #622, the Director of Care #101 stated on a specified

date, resident #026 had been administered resident #028's medications in error.

The Licensee failed to ensure that no drug was used by or administered to residents #022 and #026 in the home unless the drug has been prescribed for the residents [s. 131. (1)]

2. This finding is related to Critical Incident System report (CIS) #2982-000012-18

The licensee has failed to ensure that a specified medication was administered to resident #023 in accordance with the directions for use by the prescriber.

Medication incident #2 related to CIS #2982-000012-18 indicated resident #023 was admitted to the nursing home on a specified date. Medication reconciliation was completed and the orders were processed by the pharmacy. RPN #103 verified the written medication orders against the electronic medication administration record (eMar) for two specified medication passes. Medications were received from pharmacy and were cross referenced with the eMar which indicated resident #023 was to receive a specified amount of the medication at a specified time. Resident #023 was administered the specified amount of medication at the specified time as directed on the eMar and the medication container. RPN #103 further reviewed the written medication order for resident #023's specified medication and noted the physician's order had been misread by the registered staff and pharmacy; resident #023 should have received a lesser dosage of the specified medication than was administered.
Resident #023 was monitored, a specified treatment was administered to help stabilize the resident. Upon consult with the emergency room staff, the physician transferred the resident to the hospital. Resident #023 returned to the nursing home on a specified date, stable with no ill effect noted.

A review of the "New Admission order form" indicated on a specified date, a specified dosage of a medication was ordered for resident #023, the ordered dosage was less than the amount administered to resident #023.

During an interview with inspector #622, RPN #103 stated on a specified date when they read the new admission order for resident #023's specified medication, it appeared that a specified dosage was to be administered at the specified time. RPN #103 stated they felt the documentation matched between the order, eMAR and directions on the medication container. RPN #103 said at the end of the shift they were verifying medication orders when they noticed the error related to resident #023's specified medication. RPN #103

stated they reviewed the physician's order with the medication sheet from the admission documentation and realized resident #023 was to receive a lesser dosage of the specified medication than what had been previously administered.

During an interview with inspector #622, Director of Care (DOC) #101 acknowledged that resident #023 was administered the wrong dosage of a specified medication and was given a higher dosage than what was prescribed. Furthermore resident #023 should have received the specified dosage of the medication as ordered from the prescriber.

The licensee failed to ensure that a specified medication was administered to resident #023 in accordance with the directions for use by the prescriber. [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 that 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
and
the licensee shall 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 April, 2018

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

Original report signed by the inspector.