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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 26, 2020	2020_520622_0006	002091-20	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 MISSISSAUGA ON L4W 0E4

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)

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): February 21, 24, 25, 2020.

The following log was completed during this inspection:
Critical Incident log #002091-20/Critical Incident System report (CIS) #2982-000004-20 related to medication incidents.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Clinical Resource Nurse, the Restorative Care Lead/RAI Back-up, Registered Nurses (RNs), a Registered Practical Nurse (RPN), and the residents.

Also, during the course of the inspection, the inspector reviewed the Critical Incident System report (CIS), the hard copy and electronic health records, the licensee and pharmacy's medication management policies and procedures, staff schedules, pertinent human resource documents and observed resident care and services.

The following Inspection Protocols were used during this inspection:
Medication

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

- **2 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	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 O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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 drugs were administered to residents #001,

#002, and #003 in accordance with the directions for use specified by the prescriber.

On February 21, 2020, inspector #622 reviewed the licensee's Medication Incident Report #MIR-19519. The medication incident report stated that resident #001's specified medication was to be applied in the morning and removed at bedtime. On a specified date during morning care, RPN #100 noted that resident #001's specified medication had not been removed at bedtime, there was no ill effect to the resident.

On February 21, 2020, inspector #622 reviewed the Order tab on Point Click Care for resident #001 which indicated the resident had been ordered a specified medication to be applied in the morning and removed at bedtime.

On February 21, 2020, inspector #622 reviewed the licensee's Medication Incident Report #MIR-19516. The medication incident report stated that resident #002 required their medications crushed and they were to receive a specified medication twice daily. On a specified date during morning care, the specified medication was not crushed and found in resident #002's bed from the evening medication pass. There were no signs of pain or ill effects for resident #002 as a result.

On February 21, 2020, inspector #622 reviewed the Order Tab on Point Click Care for resident #002 which indicated the resident had been ordered a specified medication twice daily.

On February 21, 2020, inspector #622 reviewed the licensee's Medication Incident Report #MIR-19517. Resident #003 was to receive a specified medication at bedtime, the resident's specified medication was found in their bed during morning care on a specified date. There was no adverse effect noted to the resident.

On February 21, 2020, inspector #622 reviewed the Orders tab on Point Click Care for resident #003 which indicated that the resident had been ordered a specified medication by mouth two times a day at 0800 and 2100 hours.

During separate interviews with inspector #622 on February 21, 2020, RN #101 and RPN #100 stated that on a specified date, during morning care it was noted that resident #001 did not have their specified medication removed at bedtime and resident #002 and resident #003's specified medications were found in their beds from the medication pass on the evening shift.

During an interview with inspector #622 on February 25, 2020, the Assistant Director of Care (ADOC) #104 stated that on a specified date, RN #102 did not follow processes to ensure the residents took their medication and signed off that medications were given when they weren't. ADOC #104 stated that residents #001, #002 and #003 had not received their medications as prescribed when resident #001 did not have their specified medication removed at bedtime and resident #002 and resident #003's specified medications were found in their beds. [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.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a medication incident involving resident #003 was reported to the resident's substitute decision-maker.

On February 21, 2020, inspector #622 reviewed the licensee's Medication Incident Report #MIR-19517 dated a specified date and time related to resident #003 for a high alert medication which had been omitted. The incident report stated that resident #003's substitute decision maker (SDM) had not been notified as the resident often refused their medication.

During separate interviews with inspector #622 on February 21, 2020, RN #101 and RPN #100 stated that they had not notified resident #003's SDM of the medication incident which had occurred on the specified date.

During an interview with inspector #622 on February 25, 2020, Assistant Director of Care (ADOC) #104 stated that the resident family/SDMs were to be notified for medication incidents however, resident #003's SDM had not been notified. [s. 135. (1)]

Issued on this 26th day of February, 2020

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

Original report signed by the inspector.