Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 23, 2024

Inspection Number: 2024-1014-0002

Inspection Type:
Complaint
Critical Incident

Licensee: Arch Long Term Care LP by its General Partner, Arch Long-Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation

Long Term Care Home and City: Perth Community Care Centre, Perth

Lead Inspector	**Inspector Digital Signature**
Gabriella Kuilder (000726)	Gabriella Kuilder Digitally signed by Gabriella Kuilder Date: 2024.05.01 12:06:55 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 20, 21, 22, 25, 26, 27, 2024 and April 2, 2024

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake: #00105271/ CIR # 0962-000032-23, Intake: #00106654/ CIR #0962-000001-24, and Intake: #00110035/ CIR #0962-000005-24 related to infectious disease outbreaks
- Intake: #00107879/ CIR #0962-000002-24 related to an allegation of physical abuse by a resident towards another resident
- Intake: #00108466/ CIR #0962-000004-24 related to a medication incident resulting in a resident experiencing an adverse reaction

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The following intake was completed in this complaint inspection:
- Intake: #00110644 related to the allegations of staff to resident abuse

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Palliative Care

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to comply with FLTCA, 2021 s. 28 (1) 2 regarding the immediate reporting of any suspicion of resident neglect and the information upon which it is based to the Director.

Rationale and Summary:

On a specific date, a PSW (Personal Support Worker) emailed an allegation of neglect by a registered staff towards a specific resident to an Administrator.

During an interview with the Administrator, they indicated upon receipt of an email an investigation was initiated when they became aware of the allegation of neglect.

The Administrator indicated that through the investigation process the allegation of neglect by the registered staff towards a resident was unfounded.

The home's policy titled: Zero Tolerance to Resident Abuse and Neglect, 02-01-02 (revised 01 /2024) indicated, "Universal Care and the Home shall comply with FLTC Act 2021, and requires making an immediate report to the Ministry of Long-Term Care Director, where there is a reasonable suspicion, or grounds to suspect abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident".

During an interview with the Administrator, they indicated the allegation of neglect of a resident by the registered staff was not immediately submitted to the Director.

Not immediately reporting any allegation of resident neglect to the Director could potentially increase the risk of harm and injury to the resident.

Sources: Interview with an Administrator, investigation notes, email dated on a specific date to an Administrator by a PSW.
[000726]

WRITTEN NOTIFICATION: Safe storage of drugs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (a) (ii)

Safe storage of drugs

s. 138 (1) Every licensee of a long-term care home shall ensure that,

(a) drugs are stored in an area or a medication cart, (ii) that is secure and locked,

The Licensee failed to comply with O. Reg 246/22 s.138. (1) (a) (ii) by not ensuring drugs are stored in an area or medication cart that is secure and locked.

Rationale and Summary

On a specific date Inspector #000726 observed a Registered Practical Nurse (RPN) walking away from an unsecured medication cart, and left keys to the cart on the preparation area on top of the cart. The medication cart was situated in the hallway leading to the entry of the resident dining room in the home. Inspector #000726 pulled the first and second drawer of the cart and found it to be unlocked. At that time Inspector #000726 observed multiple residents walking pass the unlocked cart to the dining room.

On a specific day, Inspector #000726 observed medications for two residents left on the desk in the unsecured chartroom in the home.

On a specific day, Inspector #000726 spoke with a RPN when they returned to their medication cart. A RPN indicated they were responsible for the medication cart and acknowledged leaving the medication cart unlocked for a brief period of time During an interview with Inspector #000726, a RPN indicated they did not have pockets in their uniform large enough to hold the medication cart keys and left the keys on the cart. A RPN acknowledged receiving education related to the policy and procedure related to securing medications.

On a specific date, Inspector #000726 observed medications for two residents left on the desk in an unsecured chartroom in the home.

During an interview on a specific day, with a RPN they indicated a charge nurse was in the process of confirming medication orders with a pharmacy and forgot to secure the medications before they left an unsecured chart room.

During an interview with a Registered Nurse (RN) they indicated on a specific day, they were in the process of clarifying orders with a pharmacy, and inadvertently left the medications unsecured in the chart room. The RN stated they should have secured the medication in the locked medication cart or locked medication room.

During an interview with a DOC (Director of Care) on a specific date, they indicated registered staff were expected to ensure that medication carts and rooms were locked and secured when they were left unattended. The policy titled, Pharmacy Equipment/Supplies/Storage, 04-01-02 (revised 01/2024) indicated, a locked medication room for storage of medications is provided. Prescription medications were to be stored in locked medication carts provided by the pharmacy. The key to all locked carts or medication storage rooms must be under the control of the Registered Staff or, in their absence, the Director of Care or registered staff designate. Additionally, policy titled Pharmacy Equipment/Supplies/Storage, 04-01-02 (revised 01/2024) stated, registered staff were responsible for the safe administration of medication and were to be in control of the, medication cart, the medication cart keys, and the medication room keys at all times while on duty.

By failing to ensure that drugs were stored in an area or medication cart, that is secured and locked can increase the risk of harm or adverse event to the residents.

Sources: Inspector #000726 observations, interviews with a DOC, a RN, a RPN, Policy: Pharmacy Equipment/Supplies/Storage, 04-01-02 (revised 01/2024). [000726]

COMPLIANCE ORDER CO #001 Administration of drugs

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 140 (1)

Administration of drugs

s. 140 (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. 246/22, s. 140 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (c)]:

The Licensee shall:

A. Conduct training for a RPN on the policies and procedures related to medication management, and medication administration. Including a record of the trainer and date the training took place.

B. Conduct training for a RN on the policies and procedures related to medication management, and medication administration. Including a record of the trainer and date the training took place.

C. Develop a medication administration auditing tool to include, date audit was completed, name of auditor and, procedures for medication administration as outlined in Medication Administration, policy 04-02-01. (Revised 01/2024) are followed.

D. Conduct audits on a RPN one time per week, for five residents during a scheduled medication pass to validate adherence to medication administration procedures as outlined in the licensee's policy Medication Administration procedures. Audits to be completed for 3 weeks.

E. Keep written records for A, B, C, until the Ministry of Long-Term Care has deemed that the licensee has complied with this order.

Grounds

The licensee has failed to comply with O. Reg. 246/22, s. 140 (1) related to ensuring that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On a specific date a RPN administered medications that were not prescribed to a resident which resulted in a resident experiencing an adverse reaction requiring the transfer and admission to hospital.

Review of the medication incident report indicated on a specific date, at a specific time, the RPN administered medications to the resident that were prescribed to another resident. The Medication administration error was immediately reported by the RPN to a RN. The RN notified the attending physician and the resident's substitute-decision maker (SDM) immediately.

The medication incident report indicated the resident was to be closely monitored for any changes in their condition. The resident was assessed at three specific times and was found to be at their baseline status. At a specific time, the resident's condition changed, and they were transferred to the hospital.

Through a record review it was identified the RN and the RPN did not adhere to the policy. titled Medication Administration, 04-02-01 (revised 01/2024):

During an interview with Inspector #000726, the RPN indicated they administered medications that were not ordered for a resident, resulting in the resident experiencing an adverse reaction requiring admission to hospital. They acknowledged they did not follow procedure related medication administration. The RPN sited, workload, distractions, and compliancy during the medication pass as causes to the medication error.

During an interview with Inspector #000726, a RN indicated, the RPN prepared medications for a resident. The RN stated a RPN was behind in the medication pass and offered them assistance by administering the prepared medication to the resident The RN indicated that the medications were prepared by the RPN belonged to another resident. The RN stated the resident experienced an adverse reaction due to the interaction between the medication prescribed to the resident and medications that were prescribed to another resident.

During an interview with the DOC, they indicated the RPN administered medication to the resident that belonged to another resident in error, resulting in the resident experiencing an adverse reaction requiring a resident to be transferred to hospital. The resident was admitted to acute care, but returned from the hospital on a specific day, at their baseline status. At the time of the interview a resident remained at baseline status.

During an interview with the DOC, they indicated they were not aware the RN administered medications to the resident that were prepared by the RPN, and this was not a common practice within the home. The DOC stated they would have expected the RN to have adhered to the medication administration procedure as outlined in policy Medication Administration, 04-02-01 (revised 01/2024), when they administered the medication to the resident.

By falling to ensure no drug is used by or administered to a resident unless the drug had been prescribed resulted in the resident experiencing an adverse reaction requiring intensive care for a brief period.

Sources: Medication incident report, interview with a RPN, a RN, a DOC, Policy: Medication Administration, 04-02-01 (revised 01/2024).

[000726]

This order must be complied with by June 4, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.