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
Sep 15, 2017	2017_520622_0030	012698-17	Critical Incident System

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

2109577 ONTARIO LIMITED O/A 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): August 29, 30, 31 2017 and September 1, 5, 2017.

The following log was completed as part of this inspection:

Log#012698-17 for critical incident system (CIS) report #2982-000018-17 related to a complaint of improper/incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Assistant Director of Care (ADOC), the Clinical Nurse Manager, the Family and Community Coordinator, the Restorative Care Lead/RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Care Providers (PCP), a housekeeper, the resident and family.

Also during the course of the inspection the inspector observed resident care and services, reviewed resident health records and the nursing homes applicable complaint investigation notes, policies related to registered and non-registered staff job descriptions, complaints procedures and Medi-systems change in medication and discontinued medication policies.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Hospitalization and Change in Condition
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care specific to toileting requirements had been provided to resident #001 which resulted in the resident being incontinent of urine.

During an interview with inspector #622, the complainant indicated that on a specified date and time, they visited resident #001 and noted the care had not been provided to the resident according to the plan of care and resident #001 had been incontinent of urine. The complainant indicated he/she reported the concern to the staff, they gave resident #001 care.

Review of the most recent care plan dated a specified date indicated specific care direction related to toileting had been added to the care plan at the request of the power of attorney (POA).

During an interview with inspector #622, RPN # 112 indicated after an incident in which resident #001 sustained injury, the POA had requested specific care directions related to toileting be added to the plan of care.

During an interview with inspector #622, PCP #108 indicated on a specified date and time, the POA visited resident #001 and noted the specified care related to toileting for resident #001 had not been provided to the resident.

During an interview with inspector #622, PCP #109 indicated on a specified date, resident #001's POA arrived at the home and pointed out the specified care related to toileting according to resident #001's care plan had not been provided to resident #001 and as a result the resident was incontinent of urine.

During an interview with inspector #622, Assistant Director of Care #101 indicated that the staff should have followed the care plan, it was readily available on Point of Care.

Therefore, the licensee failed to ensure that the care set out in the plan of care specific to toileting requirements for resident #001 had been provided which resulted in resident #001 being incontinent of urine. [s. 6. (7)]

2. The licensee has failed to ensure that the staff who provide direct care to resident #001 are aware of the contents of the resident's ambulation program plan of care.

Related to Critical Incident #2982-000018-17

Resident #001 is of a specified age with specified diagnoses.

During an interview with inspector #622, the complainant indicated resident #001 had a specific ambulation program using a specified assistive device as per the information they had received from physiotherapy. The complainant further indicated that staff said there was no order for the use of the specified assistive device for ambulation. The complainant expressed concerns about communication between the home's departments.

Review of the most recent care plan indicated resident #001 had a specific ambulation program utilizing a specified assistive device.

During an interview with inspector #622, Restorative Care Lead/RAI Coordinator #110 indicated that resident #001's use of the specified assistive device started on a specified date. To communicate the plan of care to the staff, a meeting was held with staff from the floor on a specified date and a copy of care plan was placed in the restorative binder. Restorative Care Lead/RAI Coordinator #110 reviewed the restorative binder from the resident home area which included a copy of resident #001's care plan dated a specified date, that care plan gave direction for resident #001's use of the specified assistive device.

During an interview with inspector #622, Registered Nurse (RN) #111 indicated the complainant was asking for resident #001 to be walked. RN #111 also indicated she did not work in the resident home area all the time, was aware resident #001 was to be ambulated but did not know how often. RN #111 indicated she reviewed documentation

in the restorative binder for the resident home area and indicated she found the direction related to resident #001's ambulation program confusing and informed the complainant that she would seek clarification related to the resident's ambulation needs.

During an interview with inspector #622, PCP #108 indicated she was unsure of direction for resident #001's ambulation program on the specified date when the complainant was asking about resident #001 ambulating. She said she looked it up in the home's documentation but was unable to find the direction. Furthermore PCP #108 indicated she was not aware that resident #001 was to be ambulated using the specified assistive device and thought the specified assistive device was only to be used by the physiotherapist. She said staff looked into it and the complainant was told they would look into the matter.

During an interview with inspector #622, ADOC #101 indicated she would expect the assigned PCP to be most familiar with the resident's care plan. If the staff member was not a primary care giver for the resident and needed to care for that resident, she would expect them to look on the care plan for direction. She would expect all staff to safely care for all residents in the home, staff have access to the care plan on point of care via their tablets. ADOC further indicated communication of changes to a care plan is to be communicated at report. Staff should have known the direction for resident #001's ambulation program. [s. 6. (8)]

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 the care set out in the plan of care specific to toileting requirements is provided to resident #001 and that the staff who provide direct care to resident #001 are aware of the contents of the resident's ambulation program plan of care, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug has been administered to resident #001 in the home unless the drug has been prescribed for the resident.

Related to: critical incident #2982-000018-17

Critical incident #2982-000018-17 indicated on a specified date, resident #001's power of attorney (POA) submitted a written letter of complaint to the nursing home. The POA indicated within the letter of complaint that resident #001 returned to the nursing home from the hospital on a specified date, he/she received medications that were not prescribed.

On August 29, 2017, inspector #622 interviewed the POA who indicated that after resident #001 returned from a stay at the hospital on a specified date, the discharge papers had indicated the specified medication was to be on hold and to be reassessed by the doctor. The POA indicated the home started resident #001 back on the medication without the doctor's approval. The POA was notified by the attending physician of the error.

A review of the Medication and Treatment Incident Report dated a specified date, indicated resident #001's specified medication was to be placed on hold, there was a transcription error, resident #001 received the specified medication with adverse reaction requiring treatment.

A review of the New Admission Order Form dated a specified date indicated resident #001 was being readmitted to the nursing home from the hospital. Readmission orders were received from the physician which included holding the specified medication.

A review of the Medication Administration Record dated for specified dates indicated resident #001 was administered the specified medication which had been placed on hold.

During an interview with inspector #622, RPN #115 indicated resident #001 had returned to the nursing home on a specified date, the physician had given orders for resident #001's medications which included placing the specified medication on hold.

During an interview with inspector #622, RN #114 indicated resident #001 had been in the hospital and returned to the nursing home on a specified date. RN #114 indicated the physician's orders stated the specified medication was supposed to be on hold. RN #114 indicated on specified dates it was noted that the specified medication was not being held, the order was missed and the resident received a specified number of doses of the medication.

During an interview with inspector #622, ADOC #101 reviewed the medication incident and indicated the physician's order to hold the specified medication was not transcribed properly and as a result resident #001 received a specified number of doses of the medication in error. [s. 131. (1)]

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 no drug has been administered to resident #001 in the home unless the drug has been prescribed for the resident., to be implemented voluntarily.

Issued on this 18th day of September, 2017

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

Original report signed by the inspector.