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 prévue le Loi de 2007 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

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

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2018;	2018_702197_0016 (A1)	006736-18, 006738-18	Complaint

Licensee/Titulaire de permis

2109577 Ontario Limited
54 Colonial Crescent OAKVILLE ON L6J 4K9

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

Amended by JESSICA PATTISON (197) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report has been amended to extend the compliance due date and to remove a specified piece of information from the findings/grounds. These changes were made based on a request from the home.

Issued on this 18 day of September 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by JESSICA PATTISON (197) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): July 16, 17 and 19th (on-site), August 7-9 (off-site), 2018.

The following logs were inspected as part of this report:

log 006736-18 - a complaint related to a resident's medication not being given as prescribed

log 006738-18 - a complaint alleging resident abuse

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Clinical Nurse Manager, a Pharmacist, Registered Practical Nurses and residents.

The inspectors also reviewed resident's health care records, policies related to medication administration, a critical incident report, a medication and treatment incident report and the orientation checklist for registered nursing staff.

The following Inspection Protocols were used during this inspection:

Medication

Prevention of Abuse, Neglect and Retaliation

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 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. (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 :

The following finding is related to log 006736-18:

1. The licensee has failed to ensure that a medication was administered to three residents in accordance with the directions for use specified by the prescriber.

Resident #004 has a specified diagnosis and a certain medication is ordered for the following times:

- a dose at 0700, 1400 and 1600 hours
- a dose at 0900, 1130 and 1900 hours
- Extended Release dose by mouth at bedtime

On a specific date, RPN #100 administered resident #004's 0700 hour dose of the medication above at 0932 hours. The 0900 hour dose was then skipped after consultation with the Physician. A progress note was made by RPN #100 that reads as follows:

Writer new to Home and first time on unit. Writer unaware of resident's time sensitive medication. Family in and aware, as well as the RN notified the doctor. 0900 dose of medication was held due to late administration of first dose as per physician's order. Rest of specified medication doses given at appropriate times. Resident in good spirits.

At a later date, a phone interview was conducted with RPN #100. They indicated that on the date the incident above occurred, it was their first shift alone and they had not completed orientation shifts on the unit where resident #004 resides. They indicated that they were working slowing and alphabetically and that they did not realize that there was something called an advanced tab in Point Click Care that would show time-sensitive medications. They stated the function of this tab had not been reviewed in orientation. They also stated that the box the medication was

in inside the medication cart was turned upside down where there was a red sticker indicating that resident #004's specified medication was time sensitive and to ensure it is given at the right time.

During an interview with the Director of Care (DOC), they confirmed that the orientation prior to the incident did not include education for staff on the advanced tab within Point Click Care.

Further review was completed for resident #004's administration of the specified medication for the rest of that month and for a more recent two week time period.

On another date, resident #004's 1900 and 2130(extended release) hour doses were both given at 2248 hours by RPN #101. There was no explanation in the progress notes as to why the doses were late and given at almost the same time.

On another date, resident #004 received both their 0700 and 0900 hour doses of the specified medication from RPN #103 at 0842 hours. There were no progress notes made that day to explain why the two doses of medication were given late (for the 0700 dose) and at the same time.

Pharmacist #104, associated with the home, was interviewed by phone and indicated that the specified medication is a time-sensitive medication. They indicated that some residents are more sensitive to the timing than others and indicated that likely those who receive more frequent doses would be more sensitive. They also indicated that giving two doses at the same time, like in the incidents described above, should not happen as this goes against what the prescribing physician intended. Pharmacist #104 further stated that it is their understanding that the standard for medication administration would be within one hour before or after the prescribed time.

Two other residents in the home that received the same specified, time sensitive medication are residents #005 and #006. Medication administration was reviewed for these two residents for the same time period as resident #004.

Resident #005 has the following order for the specified medication:

- a dose three times a day at 0800, 1200 and 1700 hours

Upon review, the following was found, each on different dates during the review

period:

– 0800 hour dose was given at 1015 hours
– 0800 hour dose was given at 0943 hours
– 0800 hour dose was given at 0950 hours
– 0800 hour dose was given at 1012 hours
– 0800 hour dose was given at 0941 hours

Progress notes for resident #005 were reviewed for each of these dates and there was no explanation provided for the late administrations of the medication.

Resident #006 has the following orders for the specified medication:

- a dose at 0700, 1000, 1300, 1600 and 1900 hours
- an Extended Release dose at bedtime

Upon review it was found that on a specific date, resident #006's 1900 and 2100 hour doses were both given at 2237 hours. There were no progress notes that day to indicate an explanation for the late administration or why the doses were given at the same time.

During interviews with the Director of Care, they stated they could not give an explanation for the late administrations of the specified medications for residents #004, 005 and 006, other than the one for resident #004 where RPN #100 was new to the resident's unit. They also stated that the standard for administration of all medication is within one hour before or after the prescribed time. The DOC further stated that for a time-sensitive medication like the specified medication for residents #004, 005 and 006, they would expect the administration timelines to be tighter, more like ten to fifteen minutes on either side of the prescribed time.

Therefore, in multiple instances, the specified, time-sensitive medication for residents #004, 005 and 006, was not administered in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

Issued on this 18 day of September 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by JESSICA PATTISON (197) - (A1)

Inspection No. / No de l'inspection : 2018_702197_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 006736-18, 006738-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : Sep 18, 2018;(A1)

Licensee / Titulaire de permis : 2109577 Ontario Limited
54 Colonial Crescent, OAKVILLE, ON, L6J-4K9

LTC Home / Foyer de SLD : Arbour Heights
564 Tanner Drive, KINGSTON, ON, K7M-0C3

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christine Sellery

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

To 2109577 Ontario Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 131 (2).

Specifically, the licensee shall ensure:
- that residents #004, 005, 006 and any other resident that is prescribed a time-sensitive medication, receive their medication in accordance with the directions for use specified by the prescriber,
- that all registered nursing staff administering medications receive education related to time-sensitive medications, the importance of administering time-sensitive medications as prescribed and the tools available in Point Click Care to assist registered nursing staff in following the prescriber's specified administration times, and
- that the home keeps a documented record detailing the education and date it was completed, as well as the names of the registered nursing staff who attended.

Grounds / Motifs :

(A1)
1. The licensee has failed to ensure that a medication was administered to three residents in accordance with the directions for use specified by the prescriber.

Resident #004 has a specified diagnosis and a certain medication is ordered for the following times:

- a dose at 0700, 1400 and 1600 hours
- a dose at 0900, 1130 and 1900 hours
- Extended Release dose by mouth at bedtime

On a specific date, RPN #100 administered resident #004's 0700 hour dose of the medication above at 0932 hours. The 0900 hour dose was then skipped after consultation with the Physician. A progress note was made by RPN #100 that reads as follows:

Writer new to Home and first time on unit. Writer unaware of resident's time sensitive medication. Family in and aware, as well as the RN notified the doctor. 0900 dose of medication was held due to late administration of first dose as per physician's order. Rest of specified medication doses given at appropriate times. Resident in good spirits.

At a later date, a phone interview was conducted with RPN #100. They indicated that on the date the incident above occurred, it was their first shift alone and they had not completed orientation shifts on the unit where resident #004 resides. They indicated that they were working slowing and alphabetically and that they did not realize that there was something called an advanced tab in Point Click Care that would show time-sensitive medications. They stated the function of this tab had not been reviewed in orientation. They also stated that the box the medication was in inside the medication cart was turned upside down where there was a red sticker indicating that resident #004's specified medication was time sensitive and to ensure it is given at the right time.

During an interview with the Director of Care (DOC), they confirmed that the orientation prior to the incident did not include education for staff on the advanced tab within Point Click Care.

Further review was completed for resident #004's administration of the specified medication for the rest of that month and for a more recent two week time period.

On another date, resident #004's 1900 and 2130(extended release) hour doses were both given at 2248 hours by RPN #101. There was no explanation in the progress notes as to why the doses were late and given at almost the same time.

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Two other residents in the home that received the same specified, time sensitive medication are residents #005 and #006. Medication administration was reviewed for these two residents for the same time period as resident #004.

Resident #005 has the following order for the specified medication:

- a dose three times a day at 0800, 1200 and 1700 hours

Upon review, the following was found, each on different dates during the review period:

– 0800 hour dose was given at 1015 hours
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– 0800 hour dose was given at 1012 hours
– 0800 hour dose was given at 0941 hours

Progress notes for resident #005 were reviewed for each of these dates and there was no explanation provided for the late administrations of the medication.

Resident #006 has the following orders for the specified medication:

- a dose at 0700, 1000, 1300, 1600 and 1900 hours
- an Extended Release dose at bedtime

Upon review it was found that on a specific date, resident #006's 1900 and 2100 hour doses were both given at 2237 hours. There were no progress notes that day to indicate an explanation for the late administration or why the doses were given at the same time.

During interviews with the Director of Care, they stated they could not give an explanation for the late administrations of the specified medications for residents #004, 005 and 006, other than the one for resident #004 where RPN #100 was new to the resident's unit. They also stated that the standard for administration of all medication is within one hour before or after the prescribed time. The DOC further stated that for a time-sensitive medication like the specified medication for residents #004, 005 and 006, they would expect the administration timelines to be tighter, more like ten to fifteen minutes on either side of the prescribed time.

Therefore, in multiple instances, the specified, time-sensitive medication for residents #004, 005 and 006, was not administered in accordance with the directions for use specified by the prescriber.

The decision to issue this non-compliance as a compliance order was based on the following:

The severity of this non-compliance is a level two (Minimal Harm or Potential for Actual Harm) as there was the potential for negative side-effects to residents #004, 005 and 006 related to missed, late and over-lapping doses of a time-sensitive medication.

The scope of this non-compliance is determined to be a level three (widespread) as incidents of late administration for the specified time-sensitive medication occurred for three out of three residents reviewed.

The home has a level 4 compliance history (Despite MOH action (VPC, order), NC continues with original area) that includes:
-Written Notification (WN) and Voluntary Plan of Correction (VPC) issued March 21, 2018 (2018_520622_0008) (197)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :

Oct 22, 2018(A1)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 18 day of September 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by JESSICA PATTISON - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

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Service Area Office / Bureau régional de services : Ottawa