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 22, 2022	2022_505103_0007	018694-21, 001567-22	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

DARLENE MURPHY (103)

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 11, 14, 15, 2022.

Log #018694-21 (CIS #2982-000022-21) and Log #001567-22 (CIS #2982-000002-22) - alleged incidents of incompetent care of residents.

During the course of the inspection, the inspector(s) spoke with residents, Housekeeping staff, Personal Support Workers (PSW), Registered Practical Nurses (RPN), a Registered Nurse (RN), Infection, Prevention and Control (IPAC) lead, the Assistant Director of Care (ADOC), the Director of Care (DOC), and the Executive Director (ED).

During the course of the inspection, the inspector reviewed resident health care records, the home's investigation into the alleged incidents of incompetent resident care, the home's complaint's process and documented record of complaints, medication incident reports and process for reviewing them, and made observations of IPAC measures related to resident care, dining and activities.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Medication
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
- **3 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	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 LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. Persons who had reasonable grounds to suspect incompetent care of residents failed to immediately report the suspicion and the information upon which it was based immediately to the Director.

Prior to leaving the home for a personal emergency, an RN advised the Nurse Manager (NM) and the ADOC they had administered some residents their medications early. The NM investigated and found a total of six residents had medication strips missing for subsequent times. Five of the six residents involved were prescribed the same medication for both medication times. The ADOC stated they believed the incident did constitute incompetent care as residents had presumably received double doses of a medication and believed the NM had further reported the incident. The DOC stated they became aware of the incident later that week when reviewing the medication incident report. The DOC stated they also believed the incident demonstrated incompetent care due to the potential risk related to the early administration of the medications. The Director was not notified of this alleged incident until approximately one month later.

Sources: the critical incident report, interviews with ADOC and DOC. [s. 24. (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 persons who have reasonable grounds to suspect improper or incompetent care of residents immediately report the information to the Director, 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. (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 a medication was administered to a resident in accordance with the directions for use specified by the prescriber.

A resident was ordered a medication to be administered at bedtime. The medication was administered at bedtime for approximately four months and then the administration time was changed without a physician's order. The home investigated the time change of the medication and determined an RPN had changed the timing without the knowledge or consent of the physician.

Sources: Resident electronic medication record, physician orders, and interview with ADOC. [s. 131. (2)]

2. The licensee has failed to ensure medications were administered to residents in accordance with the directions for use specified by the prescriber.

An RN administered medications to six residents prior to their scheduled administration times. During an investigation by the home, the RN admitted to administering some medications prior to the prescribed times without the knowledge or consent of the physician.

Sources: Home's investigation notes, interview with ADOC and DOC. [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 medications are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1. The licensee failed to ensure a resident's substitute decision-maker was given the opportunity to participate in the implementation of the resident's plan of care related to medication.

A new medication was prescribed for a resident. During a visit with the resident, the Power of Attorney (POA) questioned the registered staff member regarding the medication being given. The POA was unaware the resident had been prescribed the medication and submitted a written complaint. The home completed an investigation and discovered an RPN had failed to notify the POA of the new order.

Sources: A resident's physician orders, complaint letter and interview with DOC. [s. 6. (5)]

Issued on this 1st day of March, 2022

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

Original report signed by the inspector.