Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Oct 9, 10, 11, 12, 15, 2012	2012_049143_0036	Complaint

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

PAUL MILLER (143)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with The Medical Advisor, the Administrator, the Assistant Director of Nursing, Registered Practical Nurse's and resident's.

During the course of the inspection, the inspector(s) completed two complaint inspections log # O-000638-12 and Log # O-001451-12.
Completed daily tours of resident home areas, observed staff providing resident care and services, reviewed medication administration policies and procedures, reviewed and obtained copies of record health care records inclusive of assessments, plan of care, physician orders and medication administration records.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Medication

Nutrition and Hydration

Personal Support Services

Findings of Non-Compliance were found during this inspection.

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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 subsections:

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 following finding is related to complaint inspection log # O-001451-12.
An attending physician ordered a medication to be administered four times per day. A review of the Medication Administration Record (MARS) June to August 2012 indicated that the resident #2 did not receive this medication as prescribed at the correct time and at the correct frequency. On June 4th the 1000 hr dose was documented as given at 1212 hr by Registered Practical Nurse S110. The 1300 hr dose was documented that day as being given at 1217 hr. The interval between medication frequency time was 5 minutes not the three hrs as prescribed. June 6th the 1000 hr dose was documented as given at 1219 hr and 1300 hr dose as 1230 hr an interval of 11 minutes. June 13th 1000 hr dose documented as given at 1224 hr and 1300 hr dose documented as given at 1226 hr. Examples were provided and discussed for incidents for June 19th, July 10th, 23rd, 29th and August 10th.
The licensee has failed to comply with Ontario Regulation 79/10 sec. 131.(2) the requirement to ensure medications are administered in accordance with the directions for use specified by the prescriber.

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 medications are administered as prescribed, to be implemented voluntarily.

Issued on this 15th day of October, 2012

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