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 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2018	2018_747725_0021	005679-18, 016540-18, 016774-18, 017022-18	Critical Incident System

Licensee/Titulaire de permis

S & R Nursing Homes Ltd.
265 North Front Street Suite 200 SARNIA ON N7T 7X1

Long-Term Care Home/Foyer de soins de longue durée

Heron Terrace Long Term Care Community
11550 McNorton Street WINDSOR ON N8P 1T9

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

CASSANDRA TAYLOR (725)

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): October 31 - November 2, 2018, and November 5, 2018.

The following intakes where completed within this inspection;
Critical Incident System (CIS) inspection: Log #005679-18 relating to a medication incident;
Critical Incident System (CIS) inspection: Log #016540-18 relating to prevention of abuse and neglect;
Critical Incident System (CIS) inspection: Log #016774-18 relating to hospitalization and significant change in status;
Critical Incident System (CIS) inspection: Log #017022-18 relating to responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, two Managers of Resident Care (MRC), one Resident Assessment Instrument Minimum Data Set (RAI MDS) Coordinator, one Medical Doctor (MD), four Registered Practical Nurses (RPN), two Personal Support Workers (PSW), one Housekeeping Aide, and one Maintenance staff.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. Ontario Regulation 79/10, s. 114(2) states that the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding a specific resident.

Information contained within the CIS report stated that the specific resident was transferred to the hospital on a specific date, with specific symptoms. Later that day a Registered Nurse (RN) #114 received a call from the hospital inquiring about the resident having received a specific drug. RN #114 reviewed the resident's documentation and found that the resident was previously receiving a different specific drug. The specific drug was discontinued on a specific date, by Medical Doctor (MD) #104, who had intended to order a different specific drug, but did not.

During a record review for the specific resident from Point Click Care (PCC) progress notes showed that on a specific date, MD #104 completed the three Month Medication Review (MMR). A dictated progress note from MD #104 on a specific date, indicated that MD #104 reviewed the resident's laboratory work and determined that the specific drug would be discontinued due to a specific lab value and a different specific drug would be ordered. A review of the three MMR and physician order sheets showed no order was written.

During a record review of the home's internal investigation, a documented interview with Pharmacist #115 was completed. Pharmacist #115 was present during rounds on the specific date. Pharmacist #115 indicated in the interview that MD #104 intended on switching to a different specific drug and that Pharmacist #115 calculated the dosage.

During record review of the home's policy titled; RCM 09-13 Medication – Ordering and Transcribing, with a last revised date of August 7, 2017, it indicated that "A review of a resident's medications will be done quarterly by the physician, pharmacist and Registered Team Members. The review will be signed by the physician and the quarterly medication review record will be placed on the resident's chart and a copy will be returned to the pharmacy. PROCEDURE: 1. Verifying that the order is complete, or follow up with the physician to obtain a complete prescription. 2. Assess the appropriateness of the medication as prescribed for the resident in the particular situation and follow up with the prescribing physician as necessary."

During an interview with the Manager of Resident Care (MRC) #101 and Administrator #102, inspector #725 asked if the policy titled; RCM 09-13 Medication – Ordering and Transcribing also pertained to medications that were discontinued. MRC #101 and Administrator #102 confirmed that this policy also pertained to discontinued medications.

During a record review of the three MMR, a specific drug with the specific indication of use was noted. The medication was marked to be discontinued. Two registered team members signed off on the three MMR and discontinued the specific drug, a medication used to manage a specific condition without a replacement medication.

The licensee has failed to ensure that the policy titled; RCM 09-13 Medication – Ordering and Transcribing was complied with during the three month medication review for the resident. [s. 8. (1) (b)]

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 where the Act or the Regulation required the licensee of long-term care home to have, institute, or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4): 4. Subject to subsection (3.1), an incident that caused an injury to a resident for which the resident was taken to the hospital and that resulted in a significant change in the resident's health condition.

A Critical Incident System (CIS) report was submitted to the Ministry of Health and Long-term Care (MOHLTC) regarding a specific resident.

Information contained within the report stated that the resident had sustained a fall on a specific date, on assessment the resident presented with specific presentation and pain.The resident was transferred to the hospital where they were diagnosed with a fracture.

During record review for the resident it was documented in Point Click Care (PCC) progress notes that the resident was diagnosed with a fracture on a specific date, and underwent surgery to repair the fracture. The resident was readmitted to the home and review of the resident's care plan indicated that the resident had a specific transfer status. The care plan was updated on a specific date, to state that the resident's transfer status had changed.

During an interview with the Manager of Resident Care (MRC) # 101 it was stated that the home was waiting to evaluate the resident's transfer status to see if a change in status had occurred before submitting a CIS report.

The licensee has failed ensure that the Director was informed of an incident that caused an injury to the specific resident which the resident was taken to the hospital and resulted in a significant change in the resident's health condition. [s. 107. (3) 4.]

Issued on this 9th day of November, 2018

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

Original report signed by the inspector.