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 # / Registre no	Type of Inspection / Genre d'inspection
Mar 29, 2017	2017_532590_0001	031395-16	Complaint

Licensee/Titulaire de permis

MIDDLESEX TERRACE LIMITED
284 CENTRAL AVENUE LONDON ON N6B 2C8

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

MIDDLESEX TERRACE
2094 GIDEON DRIVE R.R. #1 DELAWARE ON N0L 1E0

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

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 4 and 5, 2017.

The following Critical Incidents were inspected concurrently during this complaint inspection:

LSAO Log #031135-16/CIS #1030-000031-16 was related to medication administration.
LSAO Log #014254-16/CIS #1030-000017-16 was related to abuse and neglect.

This report was amended on May 5, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, one Physician, three Registered Nurses, three Registered Practical Nurses and one family member.

During the course of the inspection, the inspector(s) reviewed two resident's clinical records, documentation records from a residents hospital admission, two Critical Incident System reports and relevant policies related to this inspection.

During the course of the inspection, the inspector(s) observed staff to resident interactions and infection prevention and control practices.

The following Inspection Protocols were used during this inspection:
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that residents are protected from abuse by anyone

and free from neglect by the licensee or staff in the home.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A resident required ongoing daily monitoring of their medical condition.

A Physician's order instructed staff to complete condition specific daily monitoring. The resident had the ordered monitoring completed for the one week period, however regular monitoring after that one week time period did not take place.

The resident's care plan identified goals to maintain acceptable values for their medical condition and to minimize and prevent risk of complications. Individualized interventions were in place.

Review of the electronic Medication Administration Record (eMAR) and monitoring records over a four month period, showed that the resident's condition specific monitoring had not been completed for a three month time period.

In an interview with a RPN they said that if a physician’s order stated to complete daily monitoring of the resident's condition for a specified time period and review, they would make a note after that week in the physician’s rounds book to remind the physician to review the order. This RPN also said that the physician's rounds book only dates back six months and the home did not retain the records for that time period.

As per the Critical Incident System (CIS) report submitted to the Ministry of Health and Long Term Care (MOHLTC), the home's management team had spoken with the physician during a meeting with the family. The physician acknowledged that daily monitoring should have been completed and apologized at that time. Regular monitoring of the resident's condition was put into place at that time.

In an interview with the Administrator, they said that the physician's order regarding the monitoring of the resident's ranges were not reassessed by the physician or brought to the physician's attention that it needed to be reassessed. [s. 19. (1)]

2. A resident had a physician's order which stated the resident was to receive a specific

medication as needed based on the results of the condition specific monitoring completed.

The resident's care plan identified goals to maintain acceptable values for their medical condition and to minimize and prevent risk of complications. Individualized interventions were in place including administering medications as per physician's orders.

The resident's progress notes on a specified date, stated the resident was not feeling very well and had their condition assessed by the staff. The reading was documented as being out of acceptable range and re-checked hours later to still be out of the acceptable range. The note said the staff will continue to monitor the resident. Review of the eMAR for that date, showed that no medication was given at that time for the out of range values.

In an interview with a RPN, they stated that medication administered on an as needed basis should be documented in the eMAR and in the progress notes to provide rationale to registered staff on the oncoming shift and to ensure proper follow-up.

In an interview with the Administrator they stated that the order was in place and that medication was not given as ordered by the physician. They stated that all medications administered are to be documented on the eMAR. The Administrator further stated that the two staff members would be disciplined as a result of this inspection. [s. 19. (1)]

3. A resident was admitted to Middlesex Terrace from the hospital, and was re-admitted to the hospital several days later. They had several medical diagnosis’, one of which required specific medical interventions to be completed.

When the resident arrived to the home, they arrived with their “Discharge Medication Plan” that was completed by the hospitals physician on the morning of their discharge from hospital. The discharge medication plan stated that a specific medication was stopped. The homes registered staff were required to use two sources of information to complete the resident’s best possible medication history on the “Best Possible Medication History” (BPMH) sheet for the physician to review and order appropriate medications for the resident as outlined by the homes policy.

The homes policy titled “Medication Reconciliation”, policy 7-2 dated 01/14 stated the following:
Medication Reconciliation is a formal process which involves identifying and bringing any

discrepancies to the attention of the physician and other members of the health care team. Whenever possible, at least two sources of information are used to complete the BPMH.

Review of the BPMH sheet completed by the registered staff in the home showed that only one source of information, the Hospital Discharge sheet, was documented as used to obtain the BPMH. In a progress note a staff member documented that they had reviewed the discharged medications with the resident’s family. The Administrator said that they had directed the nurse who completed the BPMH to document the second source used for the BPMH, and further stated that upon review of the BPMH sheets, the nurse had not completed this task as directed previously.

In an interview with the resident’s family, they said that they could not recall ever reviewing medications with a nurse in the home shortly after their family member was admitted. They also could not remember if medications were reviewed with another one of their family members.

In an interview with a RN who completed the BPMH sheet, they stated that they had reviewed the medication list with the family, but the discussion was about other medications that were not identified on the list and the stopped medication was not mentioned during their conversation. The RN further stated that they had not documented the second source of information used on the BPMH as directed by the policy.

In an interview with the Administrator they said that the home did not follow their policy in regards to documenting two sources of information on the BPMH and that they had asked the staff member to document both sources.

On the resident's second day in the home, the staff received a faxed Discharge Summary document for this resident from their latest hospital admission. This discharge document contained a discharge medication list, which identified that the resident was to be on a specific medication daily. Also noted on this document was that the underlying medical condition was an issue during this hospital admission, however stabilized as evidenced by their last lab values which showed the resident was at a therapeutic medication level. The document advised that this resident remain on the identified medication and have another value checked in four weeks from this date. This discharge summary document was initialed by the homes physician as being reviewed, when the physician completed the resident’s admission assessment.

The homes physician had visited the resident and completed an assessment. On Middlesex Terrace's Admission Physical Examination form for this resident on a specified date, it was noted that the resident had a specified medical condition and was on specific medication.

In an interview with a Physician, they stated that the incident was a result of the hospitals clerical errors, in that there was a glitch in their computer system which resulted in the home receiving the wrong medication list from the hospital. They stated that the home followed their processes for new admissions. The Physician further stated that no nurse had brought forth concerns about this resident not being on appropriate medications to them.

In an interview with a RN they said that they do receive faxed Discharge Summaries on their shifts and they read and file them for the physician to review. They stated that the Discharge Summaries can arrive to the home days after the resident had already been admitted and therefore is not a reliable source to use for the BPMH. They did not recall receiving a Discharge Summary for this resident at any time.

In an interview with a RN they stated that they do receive faxed Discharge Summaries on their shifts and when they receive them they file them for the physician to review. They did not recall receiving a Discharge Summary for this resident at any time.

In an interview with the Administrator they said that this was a very unfortunate occurrence that the home is learning from. The home learned of the situation when the hospital had called the home to question if the resident was or was not on a specific medication, as they had an underlying medical condition and there were no medications listed on their medication list sent by the home. The Administrator said that the home had followed their medication reconciliation policy when the resident was admitted and that the hospital's computer system glitch is responsible for the miscommunication of medications. The Administrator stated that the home did have the Discharge Summary for this resident in their possession on the resident's second day in the home, and it might not have necessarily been read by the nurse when received, but perhaps just filed for the physician's review. The Administrator said that the physician did initial the discharge summary as being reviewed and would have expected appropriate medication orders based on the residents needs. Education sessions have been held for the staff regarding medication reconciliation process expectations including documentation and acceptable sources for medication information.

The licensee had failed to ensure that residents are free from neglect by the licensee or staff in the home.

The severity was determined to be a level three as there was actual harm to the residents. The scope of this issue was isolated to the identified residents. The home has a compliance history of this legislation, being issued a Compliance Order on June 11, 2014, in a Critical Incident inspection #2014_261522_0016. The compliance order was complied with on October 2, 2014. [s. 19. (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 residents are protected from abuse by anyone and free from neglect by the licensee or staff in the home, to be implemented voluntarily.

Issued on this 2nd day of June, 2017

[redacted]

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

Original report signed by the inspector.