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
Mar 14, 2019	2019_789435_0001	026713-18, 028477-18, 031353-18, 002521-19, 003544-19	Critical Incident System

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

AMBERLY COWPERTHWAITE (435), INA REYNOLDS (524)

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): March 11 and 12, 2019

The following intakes were completed in this Critical Incident System Inspection:
Log #026713-18, CIS #1030-000024-18
Log #028477-18, CIS #1030-000028-18
Log #031353-18, CIS #1030-000031-18
Log #002521-19, CIS #1030-000008-19 and;
Log #003544-19, CIS #1030-000012-19

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Clinical Services, Associate Director of Clinical Services, Registered Practical Nurses, Registered Nurses, and Personal Support Workers. Inspectors also completed record review and observations of residents during the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **2 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee had failed to ensure that the resident's plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs changed.

This inspection was initiated as a result of Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall incident for an identified resident. Review of the CIS report stated that the resident was found during rounds to have sustained a fall resulting in a change in condition and was transferred to hospital. After this incident, the resident was ordered to have specific interventions applied to their care.

Observation by Inspector of the identified resident's room, on two separate occasions, noted an intervention in place. Review of signage in the resident's room indicated their care requirements related to falls.

Review of the resident's clinical record showed the following:
- A report indicating separate incidents where the resident sustained a fall
- An assessment of the resident indicating their care requirements related to falls
- Care Plan which noted the resident to be at risk for falls due to disease processes and history
- Progress notes on a specific date indicating that the resident was at risk for falling and the specific intervention observed by Inspector in the resident's room and another specific intervention was implemented
- Review of the residents care plan did not indicate the use of the intervention observed to be in place by Inspector on the two separate occasions

During an interview, Personal Support Worker (PSW) #103 said that the observed intervention was implemented for the resident as an intervention to minimize injury of a potential fall. PSW #103 said they would reference the Kardex on Point of Care for resident care needs. PSW #103 reviewed the Kardex of the resident with the Inspector and said that there was no reference to the use of the intervention observed to be in place.

During an interview, Registered Practical Nurse (RPN) #104 said that the observed intervention was implemented as a result of the resident's recent fall. Inspector asked RPN #104 where staff got the information related to the observed intervention. RPN

#104 said that interventions related to falls for residents were listed on the "Fall Prevention Device" chart in the "Floor Duty Book". RPN #104 reviewed the chart with the inspector and acknowledged that there was no reference to the use of the observed intervention or devices for the resident.

During an interview with the Director of Clinical Services (DOCS) #101, they acknowledged that the plan of care related to the use of the observed intervention was not updated to reflect the care need changes and the home's expectation was that it should have been.

The licensee had failed to ensure that the plan of care for the identified resident was reviewed and revised when the resident's care needs changed. [s. 6. (10) (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 residents are reassessed and plans of care reviewed and revised at least every six months and at any other time when the resident's care needs change, or care set out in the plan is no longer necessary, 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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 had failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A CIS report was submitted to the MOHLTC which outlined an incident in which a resident was administered another resident's prescribed medications. The CIS report stated that RPN #107 confused two residents, another staff member overheard RPN #107 call the resident another resident's name, and intervened. The resident was able to spit out all of the medications administered at that time, except for an administered narcotic. The CIS report continued to state that the resident who was administered the narcotic was identified to be allergic to a specific narcotic, and the pharmacy instructed staff to continue to monitor the resident for adverse reactions. The CIS report stated that the resident had presented with adverse effects and were stable after the incident occurred.

Review of the resident's progress note on the date of the incident, stated, in part, that the resident was administered another resident's medication by accident. The note continued to state that RPN #107 was able to assist the resident to spit out most of the medications, except for a narcotic. The resident was noted to be assessed for signs and symptoms of adverse reaction as the resident was identified to be allergic to a specific narcotic. The physician and Power of Attorney (POA) for the resident was called and no concerns were noted at that time.

Review of the resident's care plan at the time of the incident noted an intervention related to pain management which included direction for staff to “Administer pain medications as per MD orders and note the effectiveness”.

Review of a report on the resident's clinical record on the date of the incident, noted that RPN #107 was administering medications to the resident when another staff member overheard RPN #107 call the resident the wrong name. At this time RPN #107 was able to retrieve all medications that were administered to the resident, except for a narcotic, also noting that the resident was allergic to a specific narcotic. The report stated that the resident was being monitored and pharmacy and physician was called. The report continued to state that RPN #107 was noted to be confused and that although they had called the resident by the wrong name prior to administration, RPN #107 did not give the resident time to respond.

Review of the resident's electronic medication administration record (eMAR) for the identified month noted no order for the narcotic that was administered.

Review of the resident's order summary report with an “Active Orders As Of” date at the time of the incident, noted no order for the administered narcotic.

Review of the home’s medication administration policy titled “Hogan Pharmacy Partners LTD. MEDICATION ADMINISTRATION IIA01- Medication Administration, General Guidelines” which was confirmed to be in place at the time of the incident by DOCS #101, stated under the “Administration” subtitle, "14. Medications supplied for one Resident are never administered to another Resident."

During an interview with DOCS #101, when asked if the resident had an order for the narcotic that was administered at the time of the incident, DOCS #101 stated that the resident did not. When asked if the resident was administered a drug that was not prescribed to them they said yes. When asked what the resident's current status was, DOCS #101 stated that the resident's status was the same as prior to the incident occurring.

The licensee had failed to ensure that the resident was not administered a drug that was not prescribed to them. [s. 131. (1)]

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

A CIS report submitted to the MOHLTC outlined an incident in which a resident was administered their prescribed medication on two consecutive identified dates, resulting in a double dose of the medication administered to the resident.

Review of the resident's progress notes on the date of the incident noted a medication incident stating that the resident received a second dose of their medication as they were administered their ordered dose on one day and administered another dose the next consecutive day. This progress note also stated that a call was placed to the physician and observations were made of the resident by staff at that time. Subsequent progress notes that were reviewed indicated that staff were monitoring the resident as instructed by pharmacy and physician, and the resident was exhibiting no adverse effects from the medication error.

Review of the resident's care plan at the time of the incident noted an intervention which stated “Give medication as per physician orders and monitor for side effects”.

Review of a report in the resident's clinical record noted that the resident received the medication on an identified date, and had the same medication administered as ordered the day prior. The report note continued to state that the physician was contacted and indicated that staff were to observe the resident as it was not an emergency.

Review of the resident's eMAR for the month in which the incident occurred, included the order and directions for use, which was noted to be signed for as administered on separate dates with an identified period of time in between doses as ordered by the physician.

Review of the resident's order summary report with an “Active Orders As Of” date on the date in which the incident occurred, noted the physician order as being to administer the prescribed medication on separate days with an identified period of time in between doses.

Review of the home’s medication administration policy titled “Hogan Pharmacy Partners LTD. MEDICATION ADMINISTRATION IIA01- Medication Administration, General Guidelines” which was confirmed to be in place at the time of the incident by DOCS #101, stated under the “Administration” subtitle, "2. Medications are administered in accordance with written orders of the prescriber".

During an interview with DOCS #101, when asked if they were familiar with the incident involving the resident they stated they were familiar with the incident and stated that Registered Nurse (RN) #108 did not follow the rights to give the medication. When asked how the incident was determined to have happened, DOCS #101 stated that RN #108 admitted that they were so used to giving that medication to the resident that RN #108 gave the medication without looking at the order. DOCS #101 continued to state that RN #108 was not used to working on the shift that the incident occurred and did not check to see that the resident had already received their ordered dose prior to administering it to the resident. When asked if the resident had exhibited an altered health status after the incident, DOCS #101 stated that the resident did not and the resident had the same health status currently, as prior to the incident.

The licensee had failed to ensure that the resident was administered their ordered medication in accordance with the directions for use specified by the prescriber. [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 that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident and that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.