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

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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
Feb 21, 2020	2020_648741_0003	024400-19, 000934-20, 001115-20	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

AYESHA SARATHY (741)

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): January 24, 27, 28, and 30, 2020

The following Critical Incident Systems (CIS) were inspected as a part of this inspection:

CIS #1030-000002-20/Log #001115-20 related to falls prevention and management
CIS #1030-000053-19/Log #024400-19 related to falls prevention and management
CIS #1030-000001-20/Log #000934-20 related to a medication incident

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), a Physiotherapist, the Director of Clinical Services, the Executive Director (ED) and two residents.

The Inspector also observed residents and medication administration passes, and reviewed relevant policies and procedures, medication incident reports and clinical records for identified residents.

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

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 has failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. The home submitted a Critical Incident System (CIS) to the Ministry of Long-Term Care (MLTC), related to the fall of an identified resident that resulted in a transfer to the hospital and an injury to the resident.

The identified resident's care plan and Kardex were reviewed on Point Click Care (PCC) and under the Falls focus an intervention was documented to be implemented in a specific way.

A progress note documented that the intervention was implemented for the resident the way it was specified in their care plan.

During an observation of the resident's room, Inspector #741 observed that the intervention was not implemented consistent with the direction in the resident's care plan. The care card above the resident's bed was reviewed and also directed staff to implement the fall intervention in a manner that was not consistent with the care plan.

In an interview with a Personal Support Worker (PSW), they said that the fall intervention was to be implemented the way it was specified on the resident's care card.

The Director of Clinical Services said in an interview that it was the home's expectation that fall prevention interventions be consistent across the plan of care. They acknowledged that the direction provided to staff regarding the implementation of the fall intervention for the identified resident was unclear.

The licensee failed to ensure that the written plan of care set out clear directions to staff related to the implementation of a falls prevention intervention for the identified resident.

B. An identified resident was included as a part of an expanded sample for this inspection. The resident's clinical record was reviewed on Point Click Care (PCC), and a progress note indicated that on a particular date they had a fall and sustained an injury.

During an observation of the resident's room, an intervention was observed to be in place as a falls prevention measure.

The resident's care plan was reviewed on PCC, and under the Falls focus the intervention for falls prevention referred to above was documented. The resident's Kardex was reviewed on PCC, and there was no documentation for this intervention as a falls prevention measure. The resident's care card on the wall was also reviewed, and there was no indication of this intervention on it.

During an interview with a Personal Support Worker (PSW), they said they used the Kardex and resident care cards for direction when providing care to residents.

In an interview with the Director of Clinical Services, they said that PSW staff do not have access to resident care plans and that they use the Kardex in Point of Care (POC) for direction to care for residents. The Director of Clinical Services said it was an expectation of the home for the intervention used for falls prevention to have been included in the resident's Kardex and on their care card and acknowledged that the direction provided to staff for resident's care was unclear.

The licensee failed to ensure that the written plan of care for the identified resident set out clear directions to staff in relation to the implementation of an intervention for falls prevention.

2. The licensee has failed to ensure that the resident's plan of care was revised when the resident's care needs changed.

A. The home submitted a Critical Incident System (CIS) to the Ministry of Long-Term Care (MLTC), related to the fall of an identified resident that resulted in a transfer to the hospital and an injury to the resident.

The resident's Fall Risk Assessments were reviewed in Point Click Care (PCC) and indicated that the resident was assessed to be at Moderate Risk for falls after their fall. The resident subsequently had additional falls and a Falls Risk Assessment was completed that indicated that their risk for falls had changed from Moderate Risk to High Risk.

The resident's Care Plan was reviewed by Inspector #741 and it was documented under the Falls Focus that the resident was at Moderate Risk for falls.

During an observation of the resident's room, the care card above their bed was reviewed and it indicated that the resident was at High Risk for falls.

The home's policy titled Fall Prevention Program – Fall Risk Care Plan Policy, Section 7.1, effective January 2016, stated that the individualized resident fall risk care plan will be reviewed and updated post fall and with any significant change in the resident's condition. In addition, the home's policy titled Fall Prevention Program – Components of Fall Prevention Program, Section 1.2, effective October 2012, stated that the resident plan of care will be consistently updated according to resident fall risk assessment findings.

During an interview with the Director of Clinical Services, they stated that it was the home's expectation that when registered staff members completed Fall Risk Assessments for residents post fall they would update their care plan, Kardex and care card. Additionally, they said it was expected that the care plan, Kardex and care card would be consistent.

The licensee failed to ensure that the identified resident's care plan was revised when the resident's Fall Risk status changed from Moderate Risk to High Risk.

B. The home submitted a Critical Incident System (CIS) to the Ministry of Long-Term Care (MLTC), related to the fall of an identified resident that resulted in a transfer to the

hospital and an injury to the resident.

The resident’s clinical record was reviewed on Point Click Care (PCC) and indicated that a Falls Risk Assessment completed after their fall assessed them to be at High Risk for falls. The resident's Fall Risk Assessments indicated that their Fall Risk status had been changed to High Risk after a previous fall they had.

The resident’s care plan was reviewed on PCC and under the Falls Focus it indicated that the resident was at Moderate Risk for falls.

During an observation of the resident’s room, the care card above the resident’s bed was reviewed and indicated that the resident was at Moderate Risk for falls.

The home’s policy titled Fall Prevention Program – Fall Risk Care Plan Policy, section 7.1, effective on January 2016, stated that the individualized resident fall risk care plan will be reviewed and updated post fall and with any significant change in the resident’s condition. In addition, the home’s policy titled Fall Prevention Program – Components of Fall Prevention Program, Section 1.2, effective October 2012, stated that the resident plan of care will be consistently updated according to resident fall risk assessment findings.

In an interview with the Director of Clinical Services, they said that the registered staff members who completed the Fall Risk Assessment after the resident’s falls should have updated the care plan, Kardex and care card and they failed to do so.

The licensee failed to ensure that the identified resident’s plan of care was revised when the resident’s Fall Risk status changed from Moderate Risk to High Risk.

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 there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, and to 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 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. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The licensee has failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of safety risks with respect to the resident.

The home submitted a Critical Incident System (CIS) to the Ministry of Long-Term Care (MLTC), related to the fall of an identified resident that resulted in a transfer to the hospital and an injury to the resident.

The resident's clinical record was reviewed in Point Click Care (PCC) and indicated that the resident had subsequent falls, after which a new intervention was initiated in their care plan to prevent further falls.

During an observation of the resident, Inspector #741 observed that the intervention specified on the resident's care plan for falls prevention was implemented.

The resident's clinical record was reviewed on PCC as well as in their paper chart, and there was no documented evidence that an interdisciplinary assessment had been

completed by the home for the intervention.

During an interview with a Physiotherapist, they were asked about the process for implementing the falls prevention intervention that the identified resident had in place. They said that to implement the intervention, they would complete an assessment, document it in a progress note, the home would contact the family to obtain consent, and then they would acquire the device for the resident. The Physiotherapist said that they were unaware that the resident had the identified intervention implemented and that they did not receive a referral to assess the resident for it nor did they recommend it for the resident.

In an interview with the Director of Clinical Services, they said that the home's process to implement the falls prevention intervention referred to above is that physiotherapy and a Registered Nurse (RN) would complete an assessment for it collaboratively, consult with the resident or family, implement it as a task in Point of Care (POC) for staff to document on and update the intervention in the resident's care plan. The Director of Clinical Services acknowledged that the intervention was implemented without an interdisciplinary assessment including physiotherapy and had not been implemented as a task in POC.

The licensee failed to ensure that the identified resident's plan of care was based on, at a minimum, an interdisciplinary assessment of safety risks.

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 a plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: Safety risks, to be implemented voluntarily.

WN #3: 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).

Findings/Faits saillants :

The licensee has 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 Critical Incident System (CIS) was submitted to the Ministry of Long-Term Care (MLTC), related to a medication incident where an identified resident received another resident's medications in error.

The CIS report and Medication Incident Report were reviewed, and stated that during a medication pass, a Registered Practical Nurse (RPN) placed one resident's medications on the dining table and the identified resident, who sat at the same table, took the medications believing they were theirs. The resident who received the incorrect medications was monitored following the medication error and it was documented that the error did not result in any adverse reactions to the resident.

The home's policy titled Self-Administration of Medications – Long-Term Care Homes, was reviewed, and stated that a physician's order must be obtained for a resident to self-administer medications.

A review of the identified resident's clinical record indicated that the resident had a physician's order to leave medications at the dining room table and at their bedside. The other resident's clinical record was also reviewed, and there was no documentation stating that they had a physician's order to leave medications at the dining table.

In an interview, the RPN who did the medication pass said that they were aware that the other resident did not have a physician's order for medications to be left at the dining table but left their medications on the dining table during the medication pass. They said that they were aware of the home's policy for self-administration of medications and but did not follow it at that time, resulting in the medication error.

In another interview, the Director of Clinical Services verified that the home's policy was that residents must have a physician's order for medications to be left at the dining table or at bedside, and that the RPN should not have left the resident's medications at the dining table when they did not have a physician's order permitting it.

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

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 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, to be implemented voluntarily.

Issued on this 21st day of February, 2020

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

Original report signed by the inspector.