Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District
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Public Report

Report Issue Date: April 19, 2023	
Inspection Number: 2023-1137-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Secord Trails Care Community, Ingersoll	
Lead Inspector Melanie Northey (563)	**Inspector Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2023.04.26 13:49:42 -04'00'
Additional Inspector(s) NA	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 11 and 13, 2023

The following intake(s) were inspected:

- Intake: #00019612 / Critical Incident (CI) #2628-000001-23 related to Fall Prevention
- Intake: #00083845 / Complaint related to Medication Management

The following **Inspection Protocols** were used during this inspection:

Medication Management
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care Revision

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that a resident was 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 changed.

Rationale & Summary
A critical incident occurred where the resident sustained an injury, was assessed and their risk for falls had increased. The Director of Care (DOC) verified the care plan was not updated to reflect the revised fall risk and acknowledged the assessment to determine fall risk was inaccurate.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) for a significant change in status assessment was completed and the care plan focus related to daily care was not revised to reflect the change in status related to the support required by staff and the level of care required for resident safety and well-being.

The Lift and Transfer Assessment was incomplete. The Transfer Lift Determination section was not completed to determine if the resident's transfer status, need for any assistive aids, if the resident had an unsteady gait, or any pain. The DOC verified the assessment was incomplete and should have been completed in full to be used to determine care plan decisions and that the RAI-Coordinator and the DOC were responsible for ensuring assessments were completed.

Personal Support Workers stated the resident required more physical assistance and staff participation in all aspects of daily care. The DOC verified the care plan was not updated to reflect the change in status related to the increased support required by staff. The resident was a risk of not receiving the appropriate level of care and assistance required for safety and well-being when the care plan was not updated to reflect the current needs for daily care.

Sources: clinical record review for the resident, review of policies and procedures, observations and resident and staff interviews.
[563]

WRITTEN NOTIFICATION: Plan of Care Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee failed to ensure that the outcomes of the care set out in the plan of care for the resident were documented.

Rationale & Summary
The documentation system used by the Personal Support Workers (PSWs) had not been updated to reflect the care needs of the resident and therefore the staff were not accurately documenting the care they provided.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) for a significant change in status assessment was completed and the care plan focus related to daily care was not revised to reflect the change in status related to the support required by staff and the level of care required for resident safety and well-being.

The Director of Care (DOC) verified the outcomes of the care set out in the plan of care were not documented. The physical assistance and staff participation increased after the critical incident occurred. The DOC stated PSWs should have documented that the daily care needs have not been provided as per resident's Kardex.

Sources: clinical record review for the resident, review of policies and procedures, observations and resident and staff interviews.
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WRITTEN NOTIFICATION: Required Programs

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

The licensee has failed to comply with the Falls Prevention and Management Program in the home for the Head Injury Routine (HIR) for the resident.

Rationale & Summary
Ontario Regulation 22/246 s. 11 (1) (b) states, “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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.”In accordance with O. Reg 246/22, s. 11. (1) b, the licensee was required to ensure the “Head Injury Routine policy and the "Falls

Prevention & Management policy was complied with.

A) The Falls Prevention & Management policy and the Head Injury Routine policy documented the expectation in the home regarding the completion of a head injury assessment.

Progress notes were reviewed to verify if HIR was directed by a physician to cease and it was not, two intervals for monitoring were missed. The Director of Care (DOC) and Executive Director were shown the Head Injury Routine paper form as part of the paper hard chart under the "Assessments" tab for the resident and verified that two intervals for monitoring were missed with no documentation. The DOC verified the HIR should have been completed to monitor neurological vital signs.

There was no neurological monitoring documented as part of the HIR for the resident at two intervals and progress notes did not identify any negative outcomes neurologically due to the lack of neurological monitoring, however the resident was at risk of developing a negative neurological outcome.

B) The Falls Prevention & Management policy documented the nurse will conduct a falls risk assessment at specific times.

The most recent Falls Risk Assessment identified the resident as a specific risk rate; however the assessment was completed incorrectly. The DOC verified the detailed fall risk assessment was not completed with the accurate clinical information to determine the appropriate fall risk level for the resident and stated the most recent Fall Risk Assessment to determine fall risk was inaccurate.

The falls prevention and management program was in place to reduce the incidence of falls and the risk of injury to residents. The resident was at risk for falls due to their fall history and the appropriate interventions determined to minimize risks of falling and risks of injury to the resident, in part, were determined by the risk level of falls. The resident was at risk of not having the appropriate interventions in place to minimize falls.

Sources: clinical record review for the resident, review of policies and procedures, observations and resident and staff interviews.
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WRITTEN NOTIFICATION: Medication Management System

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)

The licensee failed to ensure the written policies and protocols for the medication management system were implemented.

Rationale & Summary:
Ontario Regulation 22/246 s.148. (1) states, "Every licensee of a long-term care home shall ensure, as part of the medication management system, that a written policy is developed in the home that provides for the ongoing identification, destruction and disposal of drugs."

Ontario Regulation 22/246 s. 148 (2) (1) states, "The drug destruction and disposal policy must also provide for the following: That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs."

Ontario Regulation 22/246 s. 11 (1) (b) states, “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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system is complied with.”

In accordance with O. Reg 246/22, s. 11. (1) b, the licensee was required to ensure the “CareRx Policy 5-4 Drug Destruction and Disposal last revised 11/20” and the "Medications Security & Storage, VIII-E-10.10" was complied with.

The Medications Security & Storage policy documented, "Ensure the safekeeping and storage of medications are in accordance with provincial regulatory and legislative requirements."

CareRx Drug Destruction and Disposal policy documented specific practices for the safe storage and accountability of medications.

Observations were made of the medication cart with the Director of Care (DOC) and a Registered Practical Nurse (RPN) present. There was the current medication order in two pill bottles located in the first resident compartment in the drawer labelled with the resident's name and eleasticed together. The compartment next also had two of the same medication in pill bottles eleasticed together with a different date and prescription. In the same compartment there was an older dated pill bottle with the same medication.

The DOC acknowledged that the extra pill bottles of the specific medication for the resident were not destroyed according to policy and the discontinued medication was not separate from medications for administration to the resident. The medications should not be available to reuse, and they were accessible. The Medication Incident - Final Report documented a Registered Practical Nurse (RPN) administered the wrong dose (extra dose) of a medication.

The RPN stated there was a pill container with extra doses of medication left in the medication cart and there was extra medication stored in the resident's medication compartment all the time. At the time of the medication error the extra pill bottles of the medication were removed to prevent reoccurrence.

The RPN stated when there was a change in the medication order, the medication should have been replaced with the new order and the old prescription removed from the cart and destroyed.

The resident was at risk for additional medication incidents and possible adverse drug reactions when the change in order for medication was left inside the resident's medication cart compartment with the active prescription of the same medication.

Sources: clinical record review for the resident, review of policies and procedures, observations and resident and staff interviews.
[563]

WRITTEN NOTIFICATION: Administration of Drugs

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)

The licensee failed ensure that a medication was administered to the resident in accordance with the directions for use specified by the prescriber.

Rationale & Summary
A complaint was reported to the Ministry of Long-Term Care identifying a medication incident involving a resident. The complainant stated the resident received five times the amount of medication than what was prescribed.

The Medication Incident - Final Report documented a Registered Practical Nurse (RPN) administered the wrong dose (extra dose) of a medication. The Director of Care (DOC) stated the RPN confused the medication administration dates when double checking the resident's physician orders as part of the paper clinical record. The DOC stated there was no negative outcome to the resident, that the resident was monitored every shift for seven days with no concerns and was sent to acute care for follow up.

The RPN explained they confused the medication order and administered more than what was prescribed and stated there was an older container of medication left in the medication cart prescribed to the resident. The RPN stated they followed up immediately with the Registered Nurse, physician, and resident to implement monitoring to ensure the best possible medical outcome, despite the risk of a possible adverse drug reaction.

Sources:
clinical record review for the resident, review of policies and procedures, observations and resident and staff interviews.
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