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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 12, 2019	2019_790730_0015	009855-19, 010477-19	Complaint

Licensee/Titulaire de permis

Meadow Park (London) Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Meadow Park (London)
1210 Southdale Road East LONDON ON N6E 1B4

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

CHRISTINA LEGOUFFE (730), CASSANDRA ALEKSIC (689)

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): June 5, 6, 7, and 10, 2019

The following Complaint intakes were completed within this inspection:

Complaint Log #010477-19/ IL-67021-LO related to personal support services, plan of care, medication administration, and continence care.

Critical Incident System Log # 009855-19/ 2643-000009-19 related to continence care.

During the course of the inspection, the inspector(s) spoke with an Administrator, a Director of Care (DOC), a Staff Education Coordinator, a Registered Dietitian (RD), a Registered Nurse (RN), Registered Practical Nurses (RPNs), and a Personal Support Worker (PSW).

The inspector(s) also made observations of residents, resident and staff interactions and care and services. Reviewed the applicable clinical records and plans of care for the identified resident(s).

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services

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 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 a 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.

On a specified date, the Ministry of Health and Long-Term Care (MOHLTC) received a complaint which identified concerns regarding resident #001's blood glucose management.

The complainant told inspector #689, during a telephone interview, that they had concerns regarding the home's management of resident #001's blood glucose levels. The complainant stated that during a visit to the home the resident looked lethargic and had a high blood glucose level. They stated that the staff called the physician and an order was made for insulin. The complainant stated that the home was not taking action to manage the resident's blood glucose levels.

Review of the Jarlette Health Services Long Term Care Division policy titled "Resident Rights, Care and Services- Medication Management- Diabetic Care- Blood Glucose Monitoring Section: Medication Management System" under the procedure section stated in part: "Compares the results to resident's normal values. If the results are abnormally high or low, the Registered staff member will: Repeat the procedure, recalibrate the glucometer, use another glucometer, and notify the attending physician/nurse practitioner of the abnormal value."

The physician's orders for resident #001 were reviewed and showed the following:
- An order for blood glucose monitoring a specified number of times per day.

A review of the documentation for blood glucose monitoring for resident #001 for a specific time frame showed the levels were not rechecked as per the home's policy requirements.

Review of the progress notes in PCC for resident #001 showed that on a specified date at a specified time resident #001's blood glucose was high. The note stated that the physician was informed, and an order was received to give insulin stat, discontinue a specified medication, and to start the resident on a new medication the following day. The note stated that the Power of Attorney (POA) was informed.

A progress note on the same day stated that resident #001 refused to have their blood glucose retested.

A progress note on the following day stated that resident #001's family member reported to staff that the resident did not feel well and wanted to go to bed. The note stated that resident #001's vitals were checked and documented, the resident refused their dinner, and staff assisted them to bed and stated that they would continue to monitor.

A progress note on the following day stated that a family member approached staff and stated that they were concerned about resident #001. They stated that the resident was incoherent, had a runny nose, was coughing, was not making eye contact and was sleepy. They stated to staff that this was not normal for the resident. The writer stated that they took the resident's blood glucose and it was high.

A progress note on the same day stated that resident #001 was transferred to hospital.

A progress note on a specified date stated that resident #001 was treated for a variety of health concerns at the hospital.

During an interview with Registered Practical Nurse #101, they stated that they would consider 5 to 7 mmol/L a normal blood glucose range. They stated that a reading above 7 mmol/L would be considered a high blood glucose. When asked what the home's expectation was if a resident's blood glucose level was higher than their normal range they stated that they would immediately contact the physician and the family. They stated they would check the blood glucose levels three times. They stated that after noting a high reading they would check the blood glucose level again and then inform the Registered Nurse (RN) and the RN would check it again. They stated that these actions would be documented in the progress notes. When asked at what blood glucose reading

they would call the physician, RPN #101 stated that if there was a reading above 20 mmol/L they would automatically call the physician, unless otherwise specified by the physician.

During an interview with Administrator #103 they stated that an RN had been disciplined related to resident #001's blood glucose monitoring. They stated that the family of the resident had brought the concern to the attention of the home after the resident returned from hospital. Administrator #103 stated that staff had failed to follow the home's policy related to blood glucose management after the stat order for insulin was administered, as nursing staff did not attempt to recheck the resident's blood glucose after resident #001 initially refused. They stated that the nursing staff could have also called the family for assistance if they were having difficulty obtaining a reading.

Administrator #103 stated that on the following day nursing staff failed to follow the home's policy. When resident #001 had abnormally high blood glucose levels they failed to repeat the procedure, recalibrate the glucometer, or call the physician.

Administrator #103 provided inspector #730 with a copy of the discipline for RN #108 and stated that meetings with the nursing staff from the following day were ongoing and disciplinary measures were to be determined.

The licensee has failed to ensure that their policy regarding blood glucose monitoring for resident #001 was complied with. [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 their policy regarding blood glucose monitoring is complied with, 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. (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 failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The Ministry of Health and Long-Term Care (MOHLTC) received a complaint which identified concerns related to resident #001 not receiving their medications as prescribed.

A) The complainant told inspector #689, during a telephone interview, that they had concerns regarding medication administration related to an as needed (PRN) order for a specified medication, for resident #001. They stated that when the resident was admitted to the home there was a physician's order for a medication injection PRN for when the resident refused the oral medication, and that the medication was not to be administered in addition to the oral medication, but to replace it if refused. They stated that on a specified date, at a specified time nursing staff had given the resident an injection of the medication, however, the resident had not refused the oral medication that day.

The Physician's Orders for resident #001 were reviewed and showed the following:

-An order for a specified medication, with directions Give 1 tablet by mouth one time a day.

-An order for a specified medication with directions, inject a specified amount, as needed for (to be specified by physician) at a specified time as needed only if not taking orally.

A review of the electronic medication administration record (eMAR) for resident #001 for showed the following:

-The specified oral medication was documented as "administered" on two specified dates at the specified time.

-The injection of a specified medication was documented as "administered" on two specified dates.

A review of the progress notes in Point Click Care (PCC), for resident #001, showed that a family member of resident #001 informed the unit Registered Nurse (RN) that they were concerned about the administration of the medication injection by the night nurse. The family member stated that the injection was only to be administered if resident #001 refused the oral form of the medication. The family member requested that the home investigate and discipline the responsible staff members. The progress note stated that a medication incident report was completed and handed over to Administrator #103.

A review of the home's Medication Incident Forms for 2019 by inspector #730 showed a completed Medication Incident Form related to the medication injections on two specified dates.

During an interview with Registered Practical Nurse (RPN) #105, they stated that they were familiar with resident #001. They stated that on two identified dates, that the medication injections were not provided as per the physician's orders, as the medication was only to be given as an injection if the resident refused their oral medication. They stated that the resident had not refused the oral dosage and that the injections were not given at the specified time. They stated that both administration dates were medication incidents and that they had completed a Medication Incident Report related to these incidents.

During an interview with Administrator #103, they stated that the RPN administered the medication in error. They stated that to their knowledge there were no issues with resident #001 refusing the oral medication, so the injection should not have been needed.

B) A complainant told inspector #689, during a telephone interview, that they had concerns regarding medication administration related to a missed dosage of resident #001's medication on a specified date.

The physician's orders for resident #001 were reviewed and showed the following:

- an order for the specified medication

A review of the electronic medication administration record (eMAR) for resident #001

showed the following:

This medication was shown as "administered" on a specified date.

A review of the progress notes for resident #001 in PCC showed a Family Note on a specified date, which stated that the writer had called the Power of Attorney (POA) and made them aware of a missed dose of the medication the previous night.

A review of the home's Medication Incident Forms for 2019 by inspector #730 showed a completed Medication Incident Form related to a missed dosage the specified medication. The Medication Incident Form stated under "Incident Description" that the medication was still in the original wrap and that it had been charted as given.

During an interview with RPN #101, they stated that they were familiar with resident #001. They stated that the evening nurse had not provided the medication as per physician's orders and that it was considered a medication incident.

During an interview with Administrator #103 they stated that they were aware of the medication incident regarding resident #001's missed dosage of the specified medication. They stated that the medication had recently been added by the physician and came on a separate strip and the nurse had missed matching the medication.

The licensee has failed to ensure that two specified medications were administered to resident #001 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 medications are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

Issued on this 13th day of June, 2019

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

Original report signed by the inspector.