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 # / No de registre	Type of Inspection / Genre d'inspection
Oct 24, 2017	2017_418615_0019	009511-16, 009561-16, 012101-16, 012723-16, 017090-16, 017219-16, 018238-16, 018584-16, 031650-16, 031902-16, 034836-16, 001135-17, 004379-17, 006137-17, 009505-17	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

HELENE DESABRAIS (615), DONNA TIERNEY (569), NANCY SINCLAIR (537)

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): June 26, 27, 28, 29 and 30, 2017.

The following Critical Incident System (CIS) inspections were completed during this inspection:

CIS Log #009505-17 / 1030-000014-17, related to medication management;
CIS Log #006137-17 / 1030-000009-17, related to maintenance;
CIS Log #018584-16 / 1030-000022-16, related to transferring and positioning.

Related to falls prevention:
CIS Log #001135-17 / 1030-000002-17;
CIS Log #017219-16 / 1030-000018-16.

Related to prevention of abuse/neglect:
CIS Log #031650-16 / 1030-000033-16;
CIS Log #009511-16 / 1030-000007-16;
CIS Log #012101-16 / 1030-000009-16;
CIS Log #017090-16 / 1030-000019-16;
CIS Log #034836-16 / 1030-000036-16;
CIS Log #031902-16 / 1030-000034-16;
CIS Log #012723-16 / 1030-000010-16;
CIS Log #018238-16 / 1030-000021-16;
CIS Log #004379-17 / 1030-000007-17;
CIS Log #009561-16 / 1030-000006-16.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), one Nurse Manager (NM), one Dietary Aide (DA), two Registered Practical Nurses (RPN), nine Personal Support Workers (PSW) and over 13 residents.

The Inspectors also observed resident care provision, resident/staff interactions, reviewed residents' clinical records, the home investigation reports, education/training records, policies and relevant documentations.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Falls Prevention
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.

- **4 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	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 O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,
(a) the resident's care needs change; O. Reg. 79/10, s. 24 (9).
(b) the care set out in the plan is no longer necessary; or O. Reg. 79/10, s. 24 (9).
(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident was reassessed and the resident’s care needs had changed, that the care plan was reviewed and revised.

A CIS report was submitted by the home to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to a fall of a resident.

On admission to the home, it was noted that the resident had several falls in the past six months. the resident was assessed on admission as a high risk for falls and the 24-hour admission care plan was developed.

The day after their admission to the home, the resident sustained a fall with no injury noted. The resident sustained a fall at a later date, with injuries. The resident was assessed and it was determined they required the use of two devices to prevent falls. The assessment indicated this would be addressed in the care plan to minimize risks of further falls.

A review of the current plan of care for the resident did not include the addition of the use of one of the device as determined to be required in the RAP.

Further record review of the progress notes for the resident, on a specific date, stated that the resident required the use of the two devices for safety and the current care plan for the resident did not include the addition of one device again.

During an interview, the DOC stated that when a resident was assessed and falls interventions had been identified, the home's expectation was that the care plan should have been reviewed and revised.

The licensee has failed to ensure that when the resident’s care needs had changed, that the 24-hour admission care plan was reviewed and revised.

The severity was determined to be a level 3 as there was actual arm/risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 24. (9) (a)]

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 the resident is reassessed and when the resident's care needs had changed, that the care plan is reviewed and revised, 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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CIS report was submitted by the home to the MOHLTC on a specific date, related to a medication administration error to a resident where a RPN gave a medication that had been held on previous shifts. The family of the resident witnessed the medication being given and approached the Registered Nurse on shift to ask why the medication had been administered when the medication had been not given on previous shifts.

During an interview, the Administrator stated that on the evening of a specific date, a RPN administered the medication to the resident. They stated that the medication had been held on previous shifts and should not have been given to the resident. The physician's order was that the medication be given at bedtime every day and at a later date to "discontinue all oral meds". Also in the clinical record on a different date was a the physician's order to "hold that medication today."

A record review of the electronic Medication Administration Record (eMAR) noted the medication to have been recorded as "code 9- other see nurses notes". Then a

"Physicians Fax Order Sheet" showed later that the physician had returned the fax to the home with the following order: "Decrease medication to ½ previous". There was no documented evidence that this order was processed and the Administrator stated that this was found at a later date in the resident chart, and had not been processed.

On a different date, a "Consolidated Orders (chart) Report" was faxed to the physician to include the following orders for the resident stating "medication at bedtime everyday, All interim orders to be continued until next Physicians Review was signed unless a stop date is specified."

A review of the eMAR for the resident, indicated that the medication as ordered had not been given on three consecutive days, coded as "5- hold". Only on after those days there was a physician's order for the resident to discontinue the medication.

A record review and interviews determined that the medication administered was given as per the physician's order, there was no order to hold the medication, and the medication held was not per an order.

During an interview, a RPN and a RN both stated that they would not hold an ordered medication unless directed to do so by a physician.

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

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home. [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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A CIS report was submitted by the home to the MOHLTC on a specific date, related to a fall of a resident. The CIS indicated that the resident had sustained a fall on the previous day with injury.

A review of the current care plan of the resident showed that they were to have a device for safety but was not able to be detected during the resident's observation.

During an interview, a PSW stated that the resident was to have that device but was also unable to locate the device. The PSW stated that they would check the resident's kardex on Point of Care (POC) to determine if the care plan for resident had been changed. A review of the kardex on POC, observed also by the Inspector, indicated that the resident was to have the device. The device was not able to be located in the room of the resident for use.

During an interview, a RPN stated that the resident used the device, but that it could likely be removed.

During an interview, the DOC stated that if the care plan indicated that the resident was to have the device, the home's expectation would be that there would be a device for the resident to use, and care should be provided as per the plan of care. [s. 6. (7)]

2. A CIS report was submitted by the home to the MOHLTC on a specific date, related to an improper intervention for a resident. The CIS stated that a PSW was using a device with the resident alone causing a discomfort to the resident while two staff were to provide the care as per the home's policy.

A review of the the resident's MDS annual assessment, on a specific date, stated the resident needed extensive assistance of two persons for the intervention.

A review of the resident's current care plan indicated two staff assistance for the intervention and the home's policy for the use of a specific device, stated that it was mandatory to have two staff for the intervention.

During an interview, the resident stated they remembered the incident and that the PSW performed the intervention alone with the device and the resident did not feel comfortable. The resident stated that there should always be two staff doing the intervention.

During an interview, two PSWs both stated that two staff needed to be present when using the device with the resident.

During an interview, the DOC and the Administrator stated that the PSW did not follow the resident's care plan and that two staff must be present when using the device with residents and that the home's expectation was that staff would follow the resident's plan of care.

The licensee failed to ensure that the care set out in the plan of care was provided to residents as specified in the plan.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was determined to be a pattern during the course of this inspection. There was no compliance history of this legislation being issued in the home. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

Section 1(1) the Ontario Regulation 79/10 defines a "medication incident" as a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription, and includes, (a) an act or omission or commission, whether or not it results in harm, injury or death to a resident.

A CIS report was submitted by the home to the MOHLTC on a specific date, related to a medication administration error to a resident.

A review of the home's policy, titled "Medication Incident Reporting – 9-1", stated "The Medication Incident Report is used to document any incident involving medication or adverse drug reaction regardless of origin".

A review of the "Physicians Fax Order Sheet", that was sent to the home by the physician on a specific date, included an order to "decrease the medication to half previous". There was no documented evidence in the clinical record of the resident that this order

was implemented.

During an interview, the Administrator stated that the order had not been processed.

A review of the eMAR for the resident showed that on three consecutive days, the medication was coded "5 – hold". A review of the clinical record for this resident did not include any documentation to support that there was an order for this medication to be held.

During an interview, the Administrator acknowledged that the Medication Incident Reports had not been initiated with regards to that medication incident.

A record review and interviews determined that a physician's order had not been processed to alert staff of a change in medication orders. Also, medications were not given as per prescribed orders. Medication incident reports were not initiated for either incident.

The licensee failed to ensure that the medication incident involving the resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

The severity was determined to be a level 1 as there was minimum risk. The scope of this issue was determined to be isolated during the course of this inspection. There was no compliance history of this legislation being issued in the home [s. 135. (1)]

Issued on this 3rd day of November, 2017

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

Original report signed by the inspector.