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
Jan 24, 2022	2021_769646_0024	010758-21, 017483-21	Complaint

Licensee/Titulaire de permis

Mississauga Long Term Care Facility Inc.
26 Peter Street North Mississauga ON L5H 2G7

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

Mississauga Long Term Care Facility
26 Peter Street North Mississauga ON L5H 2G7

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

IVY LAM (646)

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): December 21 and 23, 2021; and January 4 and 5, 2022.

The following Complaint intakes were completed during this inspection:
- Log #010758-21 related to allegations of abuse and neglect, and hospitalization and change in condition, and
- Log #017483-21 related to hospitalization and change in condition, and medication management.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Clinical Practice Coordinator, Hospital Nurse Practitioner (NP), Resident Care Coordinator, Infection Prevention and Control (IPAC) lead, Physiotherapist (PT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Substitute Decision Makers, Family Members, Complainants, and Residents.

During the course of the inspection, the inspector observed staff to resident interactions, reviewed residents' clinical records, staffing schedules, pertinent policies and procedures, and observed IPAC practices.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. 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 a drug was administered to a resident in

accordance with the directions for use specified by the prescriber.

A resident was admitted to the hospital related to identified conditions, and changes were made to the resident's medication regimen at the hospital.

Among these, the tablet dosage in one medication was changed.

A Registered Nurse (RN) completed the initial admission medication reconciliation, but transcribed the wrong dosage for the tablets on the order. A Registered Practical Nurse (RPN) completed the second check, and the home’s physician signed off on the admission medication reconciliation, but no one noticed that the medication was not documented as per the resident’s medication order.

Five days after the resident's readmission to the home, the home’s physician also documented their acknowledgement that the resident’s medication dosages changed per the medication changes made in the hospital - including the change in the identified medication.

However, the transcription error was not discovered, and the resident was administered the wrong dose of the identified medication daily for 53 days.

The resident’s clinical records during the 53 days indicated the resident remained in stable condition. Interviews with a PSW, registered staff, and clinical practice coordinator indicated they did not notice physical changes to the resident’s condition during the identified dates.

The RN indicated they had made a mistake and transcribed the medication dosage incorrectly. They further indicated the resident had returned to the home near the pharmacy order cut-off time, and the RN was in a rush to send the order to the pharmacy.

The RPN indicated they would usually check the original hospital medication list and cross reference with the first nurse’s medication reconciliation documentation, but they were not sure why they did not see the error in dosage of the medication.

The Clinical Practice Coordinator and the Director of Care (DOC) indicated an error was made by first nurse who completed the admission medication reconciliation, and not caught by the second nurse, resulting in the medication not being administered to the

resident in accordance with the directions for use as specified by the prescriber. They further indicated that the home will take measures in educating the registered staff and changes in practice to minimize risk of future medication errors.

Sources: Record review of the resident's hospital discharge medications; Admission Medication Reconciliation; resident's eMAR; Observations of resident, staff and resident interactions, and home's medication process; Interviews with RN, RPN, Clinical Practice Coordinator, Director of Care (DOC), and other staff.] [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.

Issued on this 28th day of January, 2022

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

Original report signed by the inspector.