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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 14, 2021	2021_526645_0014	017156-20, 022447-20, 022701-20, 000520-21, 001219-21, 010392-21, 014675-21	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Peel
10 Peel Centre Drive Suite B, 3rd Floor Brampton ON L6T 4B9

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

Sheridan Villa
2460 Truscott Drive Mississauga ON L5J 3Z8

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

DEREGE GEDA (645)

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): October 4, 5, 6, 7, 12, 13, 14, 15, 18, 19, 20, 21, 22, 26, 27, 29, November 1, 2 and 3, 2021.

This inspection was completed to inspect upon the following Critical Incident System (CIS) report intakes:

- intake log# 022447-20 (CIS #M572-000024-20), related to the unexpected death of a resident,
- intake log# 017156-20 (CIS #M572-000020-20), related to medication management,
- intake log# 010392-21 (CIS #M572-000021-21), related to responsive behavior,
- intakes log# 022701-20 (CIS #M572-000025-20) and 014675-21 (CIS #M572-000025-21), both related to fall prevention and management and
- intakes log# 000520-21 (CIS #M572-000003-21) and 001219-21 (CIS #M572-000005-21), both related to prevention of abuse and neglect.

One Voluntary Plan of Correction (VPC) related to LTCHA, 2007, c.8, s. 5, identified in a concurrent complaint inspection #2021_955645_0015 (Log # 017050-21), is issued in this report.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Nursing (DON), Supervisor of Care (SOC), Registered Nurses(RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

During the course of the inspection, the inspector observed the provision of care, medication administration procedures, services and supplies; reviewed records including but not limited to relevant training records, incident investigation notes, policies and procedures, residents' clinical health records, and staff schedules.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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 LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its resident.

The Ministry of Long-Term Care (MLTC) received a complaint from a family member of

resident #001. The complainant stated that resident #001's health condition deteriorated in September 2021. The nurse practitioner (NP) assessed the resident and ordered an identified type of diagnostic testing. The complainant stated that the diagnostic testing was not done in a timely manner, resident was not hospitalized or assessed by the physician when their condition declined.

The progress notes indicated that the NP ordered the first diagnostic testing in mid September and the second repeat testing at the end of September as the resident's health condition further declined. The record indicated that both diagnostic testings were not done in a timely manner.

The DOC and SOC #101 confirmed that both testing orders from the NP were not done in a timely manner delaying treatment. The DOC indicated that it was the expectation of the home that residents receive appropriate and safe care that meets their healthcare needs.

Failure to assess, evaluate, and follow interventions as identified in the resident’s plan of care may have contributed to the decline in the resident’s health condition.

Sources: Care Plan for resident #001, progress notes and interviews with the SOC and DOC. [s. 5.]

2. A Critical Incident System (CIS) report was submitted to the MLTC regarding a medication incident involving resident #003. The report indicated the resident developed an adverse drug reaction after receiving an identified type of medication.

The home’s investigation note indicated that NP #103 prescribed the identified medication after acknowledging the potential side effects and cross-reactivity rate with other medications. During the home’s investigation, the NP indicated that they felt comfortable prescribing the medication as the cross-reactivity risk was low.

The progress notes indicated that the NP left a voice message to notify the resident’s family member about the new medication, but the name of the drug or potential risk associated with the drug was not discussed. The notes also indicated that neither the physician nor the on-call pharmacist were consulted regarding the risk.

In August 2020, the resident developed an adverse reaction to the medication, was assessed by physician and the medication was stopped.

Interview with NP #103 indicated that they were aware about the potential risk and decided to prescribe the medication as the risk was low. They confirmed that they did not consult with the physician/pharmacist and the family member about the possible risk associated with prescribing the medication.

Interview with Pharmacist #104 indicated that there was a potential risk associated with prescribing the medication and confirmed that alternative drug types should have been considered to avoid the risk. They indicated that they normally would advise physicians/NPs about potential drug reactivity, but in this case, there were not made aware of the medication order.

Failure to evaluate the potential adverse drug reactions, and involve Physician/pharmacist and family members to make an informed care decision, would compromise the safety and well-being of residents.

Sources: Care Plan for resident #001, progress notes and interviews with the NP and Pharmacist. [s. 5.]

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 the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #001 as specified in their plan when their Advanced Care Directive was not followed.

Resident #001's Advanced Care Directive and plan of care in September 2021, indicated that resident #001 required a specific type of intervention when their health condition change.

The resident's clinical records indicated that the resident did not receive the identified intervention as specified in their plan of care when their health condition changed.

The DOC and SOC #101 indicated that the resident did not receive care as specified in their plan of care when their health condition declined.

Failure to assess and follow interventions as identified in the resident’s plan of care may have contributed to the decline in the resident’s health condition.

Sources: Care Plan for resident #001, progress notes and interviews with the DOC and SOC. [s. 6. (7)]

2. The licensee has failed to ensure that when resident #002 was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A CIS report was submitted to the MLTC in September 2021, indicating resident #001 had an identified type of incident and subsequently sustained an injury.

The progress notes indicated that the resident had multiple recurring incidents in May, June, July and August, 2021. The resident's plan of care was updated with incident prevention interventions in May and after sustaining injury in September 2021. The plan of care was not updated, interventions were not evaluated for effectiveness and new interventions were not implemented for incidents in June, July and August, 2021.

Interview with SOC #100 indicated that interventions were not developed and care plan was not updated when the resident had the identified incidents in June, July and August, 2021. They indicated that registered staff are expected to reassess the resident, develop interventions and update the plan of care to prevent recurring incidents.

Sources: resident #002’s plan of care and progress notes, post incident assessment records and interviews with RN #105 and SOC. [s. 6. (11) (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 the care set out in the plan of care was provided to residents as specified in their plan and when a resident was reassessed and the plan of care was revised because the care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 16th day of November, 2021

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

Original report signed by the inspector.