Ontario

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

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: July 10, 2024
Inspection Number: 2024-1581-0003
Inspection Type: Complaint Critical Incident
Licensee: The Reqional Municipality of Peel
Long Term Care Home and City: Sheridan Villa, Mississauqa

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 20, 21, 24, 26, 27, 2024 and July 3, 4, 2024
The inspection occurred offsite on the following date(s): June 28, 2024

The following intake(s) were inspected:

- Intake: #00113442 - IL-0124985-HA- Complaint- Concerns regarding plan of care, administration of drugs and continence care and bowel management for resident.
- Intake: #00113824 - [CI] 000015-24 - Physical abuse to Resident.

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Staffing, Training and Care Standards

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: 0. Reg. 246/22, s. 138 (1) (a) (ii)
Safe storage of drugs
s. 138 (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked,
The licensee has failed to ensure the medication cart was secured and locked when left unattended.

On two separate days, inspector observed that the medication cart was unlocked and the screen was left unsupervised when staff stepped away to administer medication. When staff returned to the medication cart, they then locked the cart.

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

Hamilton District
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

During an interview with both staff, they acknowledged that the medication cart should be locked when stepping away and each time it is left unattended.

Remedied taken before the conclusion of the Inspection:
Once staff were made aware of the observation, the cart was locked each time it was left unattended.

Not locking the medication cart puts the resident's safety at risk.

Sources: Observation of medication cart Interview with staff. [000848]

Date Remedy Implemented: June 20, 2024, and July 3, 2024.

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
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.

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

Rationale and Summary
One day a resident was observed in their home area for two hours and was not checked or changed by staff during this period. Private caregiver was present with the resident during this period and stated that the resident was already showered, groomed, and changed in the morning when she arrived earlier in the morning.

Inspectors returned to the unit after an hour and confirmed with the private caregiver that the resident had not been checked or changed since the beginning of her shift for a period of six hours. The resident's care plan indicated that they are on a check and change program every two hours which was not followed.

During an interview with staff, they confirmed that the resident was not checked nor changed for six hours.

Not following the care plan puts the resident at risk for skin breakdown.

Sources: Observation of resident; Record review of resident's care plan; Interview with staff. [000848]

WRITTEN NOTIFICATION: Policies and Records

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 11(1) (b)
Policies, etc., to be followed, and records
s. 11(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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The licensee has failed to ensure that the Ordering, Re-ordering, and Receiving Medication into the Centre policy is complied with, specifically ensuring that an existing order is discontinued and a new order is transcribed when revisions needs to be made.

Rationale and Summary

Sheridan Villa's Ordering, Re-ordering and Receiving Medication into the Centre policy states that the RN or RPN must ensure that all existing orders for the same medication must be discontinued before writing a change in direction. Sheridan Villa's Ordering, Re-ordering and Receiving Medication into the Centre policy was not followed by staff. A resident's medication order was transcribed on the Digital Prescriber's Orders sheet. The original order was written in black with the administration time written in blue in a different handwriting. There were two signatures indicating that two different people wrote the single order.

During an interview with one staff and the DOC, both staff confirmed that the old order is discontinued, and a new order is transcribed and signed if revisions need to be made and that the time added to the medication order dated was written in by a different person.

Not following Sheridan Villa's Ordering, Re-ordering and Receiving Medication into the Centre policy puts residents at risk of a medication incident.

Sources: Record review of Sheridan Villa's Ordering, Re-ordering and Receiving Medication into the Centre policy; Resident's medication order; Interview with staff. [000848]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: 0. Reg. 246/22, s. 140 (2)

Administration of drugs

s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. 0. Reg. 246/22, s. 140 (2).

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

Rationale and Summary
On two separate days, staff administered a medication to a resident at a different time scheduled time, when it should have been administered at the previously scheduled time. The order was unclear as per the progress notes; however, it was not clarified on for two days after it was ordered. The medication was not administered in accordance with the directions of the prescriber.

During an interview with staff, they indicated that the medication should have been resumed as per the previously scheduled time.

Administering the medication at an incorrect time puts the resident at risk of adverse events.

Sources: Progress notes by registered staff; Electronic Medication Administration Record; Digital Prescriber Order sheet; Interview with staff. 1000848]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: 0. Reg. 246/22, s. 147 (1) (a)
Medication incidents and adverse drug reactions
s. 147 (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident, every adverse drug reaction, every use of glucagon, every incident of severe hypoglycemia and every incident of unresponsive hypoglycemia involving a resident is,

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and

The licensee has failed to ensure that every medication incident involving a resident is documented with a record of the immediate actions taken to assess and maintain the resident's health.

Rationale and Summary
On two separate days, staff administered a medication to a resident at a different time scheduled time, when it should have been administered at the previously scheduled time. The order was unclear as per the progress notes; however, it was not clarified on for two days after it was ordered. A medication incident report documenting the immediate actions taken to assess and maintain resident's health was not completed for this occurrence.

During an interview with the DOC, they acknowledged that the practice for resumed medications without a start time is to refer the previous scheduled time and that a medication incident report was not completed for this medication error, and it should have been.

Not documenting the immediate actions taken poses a risk to assess and maintain the resident's health.

Sources: Interview with DOC. 1000848]

COMPLIANCE ORDER CO #001Policies, etc., to be followed, and records

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: 0. Reg. 246/22, s. 11(1) (b)
Policies, etc., to be followed, and records
s. 11(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, program, procedure, strategy, initiative or system, the licensee is required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system,
(b) is complied with.

The Inspector is ordering the Licensee to prepare, submit and implement a plan to ensure compliance with 0. Reg. 246/22, s. 11(1) (b) [FLTCA, 2021, s. 155 (1) (b)]:
The plan must include but is not limited to:
The licensee shall prepare, submit and implement a plan to ensure registered staff are following the home's management of diabetes program specifically related to two registered staff verifying prior to administering high alert medication to residents. The plan must include but is not limited to:

· The creation of a process for registered staff to ensure an independent double check is obtained prior to administering high alert medication to residents.
· The process should specify the hierarchy for verifying high alert medication when there is insufficient staffing such as an alternate staff that should be called.
· The compliance plan should provide education for registered staff on the steps for verifying high alert medication prior to administration.
· Document the education, including the date and the staff member who provided the education and plan of educating staff who are absent.
· The home shall perform an audit for two weeks, to ensure that staff are verifying when administering high alert medication.

Please submit the written plan for achieving compliance for inspection #2024-1581-0003 to LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by September 27, 2024.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that registered staff are complying with the home's management of diabetes program related to verifying an high alert medication dose prior to administration.

Rationale and Summary
When registered staff administer a high-risk medication, two registered staff must check and verify prior to administering the drug to a resident. This is stated in the home's Management of Diabetes Program. On two separate days, staff were observed administering multiple doses of high alert medication to residents without having another staff verify. One staff confirmed that high alert medication was administered to residents without verification by another staff. Another staff stated during, the charge nurse was called, however they were unavailable.

During an interview, two staff confirmed that two registered staff must verify prior to administering high alert medication.

Failure of the licensee to ensure that staff are following the home's management of diabetes program and the administration verification process may result in the resident's health and safety being compromised.

Sources: Observation of staff, Sheridan Villa's Management of Diabetes Program, Interviews with staff. [000848]

This order must be complied with by September 27, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021(Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.