Ontario

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

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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 13, 2023	
Inspection Number: 2023-1447-0005	
Inspection Type: Complaint Critical Incident	
Licensee: AXR Operating (National) LP, by its general partners	
Long Term Care Home and City: McGarrell Place, London	
Lead Inspector Peter Hannaberg (721821)	**Inspector Digital Signature** Peter Benjamin Hannaberg Digitally signed by Peter Benjamin Hannaberg Date: 2023.09.14 10:16:39 -04'00'
Additional Inspector(s) Leah Carrier (000748) Meagan McGregor (721) Stacey Sullo (000750)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29, 30, and 31, 2023.

The following intake(s) were inspected:

- Intake #00021660 / CI# 2964-000014-23 was related to a medication incident/adverse drug reaction,
- Intake #00087910 / CI# 2964-000023-23 was related to a resident fall, and
- Intake #00089220 was a complaint related to multiple areas of care.

The following intake(s) were also completed:

- Intakes #00020240 / CI# 2964-000009-23, 00083918 / CI# 2964-000018-23, and 00094112 / CI# 2964-000030-23 were each related to falls prevention and management.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (2)

A resident's care plan directed staff to refer to the resident's beside logo for required transfer techniques, however, the resident's assessed transfer technique was different than their bedside logo.

In interviews with staff members, it was confirmed that the bedside logo should be the same as the resident's assessed transfer technique. The bedside logo was updated to the correct transfer technique before the conclusion of the inspection.

Sources: staff interviews, observations of the resident's room, the resident's care plan, and record review of policy #CARE6-O10.03 titled "Assessments for Lifts and Transfers".
[000748]

Date Remedy Implemented: August 31, 2023

WRITTEN NOTIFICATION: Plan of care

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

The licensee has failed to ensure that the written plan of care for a resident set out clear directions to staff and others who provided care to the resident.

Rationale and Summary
The resident's plan of care showed that they required a certain intervention. Based on an

interview with the home's physician and a review of their progress notes, the intervention was to be used at a certain time of day. When the order for the intervention was written, it was unclear when it should have been applied.

Based on observations and staff interviews during the inspection, the intervention was not being applied as intended which resulted in inconsistencies in the care provided.

There was a risk to the resident for further complications when care was being provided inconsistently due to unclear directions in the resident's plan of care.

Sources: the resident's orders, progress notes, direct observations, and interviews with home staff and the resident's physician.

[721821]

WRITTEN NOTIFICATION: Plan of care

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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

Rationale and Summary
A resident was identified as having a risk for falls, and as per their care plan, was required to have a certain falls and injury prevention intervention in place. In May 2023, the resident had a fall and was assessed by a Registered Nurse, where it was documented that the resident did not have the falls and injury prevention intervention in place.

The resident was at increased risk for injury when the home did not comply with the care specified in the resident's care plan.

Sources: Interview with the Registered Nurse, and record review of the resident's care plan and progress notes.

[000748]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (1)

The licensee has failed to ensure that no drug was used by or administered to a resident unless the drug was prescribed for that resident.

Rationale and Summary
In February 2023, a resident was administered medications that were prescribed for another resident. A Registered Nurse (RN) confirmed the medication error occurred.

The medication incident report indicated that the medication error was a result of the Registered Practical Nurse (RPN) not following the home's medication administration policy - administering the right medication, to the right resident. The medication error was also confirmed by the Regional Manager and Assistant Director of Care (ADOC).

Sources: The home's medication incident report analysis, Medication Administration Policy (reviewed date: March 31, 2023), the resident's progress notes, and interviews with staff.

[000750]

WRITTEN NOTIFICATION: Residents' drug regimes

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 146 (a)

The licensee has failed to ensure that when resident #001 was prescribed a certain type of medication, that there was monitoring and documentation of the resident's response and the effectiveness of the medications.

Rationale and Summary
Upon admission into the long-term care home (LTCH), a resident was required to have monitoring of one of their prescribed medications which was not completed.

During an interview with a Registered Nurse (RN), it was stated that every resident admitted into the LTCH with certain medications were to be placed on a medication monitoring protocol which was to be completed by the nursing staff over a two week period. During the interview with the RN, they stated the monitoring tool is stored in the resident's physical chart. Inspector

#000750 and the RN reviewed the resident's physical chart and were unable to locate the monitoring tool. Inspector #000750 confirmed with the Regional Manager of the home that there would be no other location that the monitoring tool would be located.

Sources: the resident's physical paper chart, the medication policy (index CARE13-O10.13 reviewed date March 31, 2023), and interviews with staff.

[000750]

WRITTEN NOTIFICATION: Medication incidents and adverse drug reactions

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 147 (1) (a)

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.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a medication incident reporting system in place and was complied with. Specifically, staff did not comply with the policy "Medication Incident".

Rationale and Summary
In February 2023, a medication error occurred resulting in a resident receiving medications that were prescribed for another resident. The medication incident was identified by the Registered Practical Nurse (RPN) who made the medication error however the incident was not documented per the home's policy into their Medication Incident Reporting System (MIRS) immediately upon the discovery of the medication error. The incident was documented in MIRS the following day by the Assistant Director of Care.

Interviews with the Regional Manager, and two registered nursing staff confirmed that the medication error was not reported and documented as per policy.

Sources: Medication incident policy (index CARE13-O30.01, reviewed March 31, 2023), the medication incident report, and interviews with staff.

[000750]