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
May 2, 2018	2018_603194_0009	002871-18, 002973-18, 005068-18	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Ballycliffe Long Term Care Residence
70 Station Street AJAX ON L1S 1R9

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

CHANTAL LAFRENIERE (194), BAIYE OROCK (624), CRISTINA MONTOYA (461)

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): April 3, 4, 5, and 6, 2018

Complaint Logs #002871-18, 002973-18, 005068-18 related to resident care.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Physician, Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Registered Dietitian (RDs), Dietary Aid (DAs), Personal Support Workers (PSWs) and Residents.

The inspectors also observed medication administration, meal and snack services, tray services, and provision of staff-to-resident care. Inspectors reviewed Clinical Health Records for identified residents, Medication Audit Report, Resident Council Minutes, Food Committee Minutes, resident diet list, and relevant policies.

The following Inspection Protocols were used during this inspection:
Dining Observation
Medication
Nutrition and Hydration
Pain
Personal Support Services
Snack Observation

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. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating

or drinking is served a meal until someone is available to provide the assistance required by the resident.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC), alleging that residents were not being fed in the home and when residents received food trays delivered to their rooms, a single staff member was observed assisting more than six residents with their meals within 30 minutes.

On an identified date, Inspector #624 observed the provision of the meal tray service being conducted by PSW#112 and student PSW #129. At an identified time, PSW #129 was observed to place a meal tray in the room of resident #016 who was observed to be sleeping at the time. Intermittent observations were made during a 27 minute period, which revealed that the resident continued sleeping while the food tray was placed at the bedside. Resident #016 was provided assistance with the meal by PSW#111, 32 minutes after the tray was served.

In an interview on an identified date, with PSWs #112, #129 and RPN #117, by Inspector #624, all indicated that the expectation in the home is that residents are not served a meal until there is someone to assist them, if they need assistance. All interviewed staff indicated that resident #016 needed total assistance with feeding and PSW #112 and #129 indicated that this assistance was not provided when resident #016's meal tray was served to the room.

On an identified date, Inspector #461 observed the provision of the meal tray service by PSW #112. At an identified time, observed that PSW #112 placed resident #005's meal tray on the bedside table, out of resident's reach. Ten minutes later, PSW#112 positioned resident #005 for feeding but did not begin to feed the resident. RN #127 was observed feeding the resident twenty minutes after the tray was served.

At an identified time, PSW #112 placed resident #020's meal tray on the bedside table. PSW #112 indicated having planned to feed resident #018 first, then assist resident #020. Seventeen minutes later, resident #020 was still waiting for feeding assistance. RN #127 indicated to inspector #461 that resident #020 was assisted with the meal 30 minutes after the tray was served.

In an interview on an identified date, with the Registered Dietitian and Administrator, both confirmed that the home's expectation was that residents must be served meals only when there is a staff member available to assist with eating, including those residents

receiving a tray service.

The licensee failed to ensure that meal tray service for resident #005 who waited 20 minutes, resident #016 who waited 32 minutes, and resident #020 who waited 30 minutes was served before someone was available to provide assistance with the tray service. [s. 73. (2) (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 by ensuring that no residents who require assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, 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 are administered to residents in accordance with the directions for use specified by the prescriber

A complaint was received on an identified date, related to medication administration involving resident #001. The complaint indicated that resident #001's medication was not administered after meals as prescribed.

Interview with RPN #117 was conducted by inspector #194, related to resident #001's medication administration on an identified date. The RPN indicated being aware that resident #001 was to have medications administered after meals. Inspector #194 reviewed the medication administration audit report for resident #001 for an identified

date, which indicated that medication was scheduled to be administered at a specific time. RPN #117 confirmed that the medication was administered to resident #001prior to the meal.

Medication Administration Policy, LTC-CA-WQ-200-06-01, dated December 2017 indicated:
12. Administer the medication as close to the scheduled time as possible and within 1 hour before or after the designated time.

On an identified date a Medication Audit Report for resident #001 for a 13 day period was completed by inspector #194, which identified all late medication administrations.

On an identified date, a Medication Audit Report was reviewed by inspector #194 and identified that 27 residents in two separate home areas and 9 residents in another home area were administered their medications more than one hour after their prescribed time.

On an identified date, inspector #194 observed RPN #102 administering 0800 hour medications to residents in the dining room. The RPN indicated to inspector #194 during interview that five residents had not received their 0800 hour medications. RPN #102 indicated during interview related to the Medication Audit Report, that the medications for resident #001on an identified date were administered late.

RPN #120 was interviewed by inspector #194 related to resident #001's medication audit report. RPN #120 confirmed that on seven identified dates, the medications for resident #001 were administered late.

RPN #108 indicated to inspector #194 during interview that nine residents had not received their medication within the one hour timeline.

Resident #014 was scheduled to receive medication at an identified time and were administered by RPN # 108, 1 hour and 31 min late.

Resident #009 was scheduled to received medications at an identified time and were administered by RPN #102, 2 hours and 13 minutes late.

The licensee failed to ensure that drugs were administered by RPN #102, #108 and #120 to residents #014, #009 and #001 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]0

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 The licensee shall 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 is provided to the resident as specified in the plan.

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date, alleging that residents were not being fed in the home and when residents received food trays delivered to their rooms, a single staff member was observed assisting more than six residents with their meals within 30 minutes.

On an identified date, inspector #461 observed meal service in the dining room. PSW #130 served a nutritional supplement to resident #005, while resident was being fed by nursing student #121. PSW #130 indicated to the Inspector that a mistake was made when serving resident #005 a nutritional supplement as it was not listed in the "diet book" to give to the resident with meals.

On an identified date, inspector #461 observed the provision of two separate meal tray service, the following was noted:

- At an identified time, PSW #101 served to resident #005 a meal tray containing a

regular meal. The PSW #101 indicated that resident had difficulty chewing, for which the resident received a minced diet and one of the meal items should have been chopped up. The Dietary Aide (DA) #123 was present on the floor and observed the resident’s diet. DA #123 confirmed that the resident was given the wrong diet texture for vegetables.

- At an identified time, PSW #112 indicated that resident #021 was served the meal tray. Thirty-five minutes later, inspector #461observed that resident #021 had not received assistance with the meal.

Review of resident #005’s current written plan of care under the focus of eating indicated that staff was to provide extensive assistance with eating and staff to initiate feeding. Resident #005's nutritional interventions included to provide a regular diet with minced texture and a nutritional supplement at all meals. The “diet book” located in the kitchen and on the snack carts did not list the nutritional supplement at meals as an intervention for resident #005.

Review of resident #021’s current written plan of care indicated that staff was to provide some physical assistance with eating; staff to return to table at least three times to ensure completion of the meal and provide assistance as needed.

In an interview on an identified date, RN #127 indicated that resident #021 indicated not knowing that the meal tray had been served in the resident's bedroom one hour after the meal, the resident began eating independently with the RN's encouragement. RN #127 indicated that resident required reminders to eat and should have been assisted with the meal earlier.

In an interview on an identfied date, the Registered Dietitian (RD) confirmed that resident #005 received a full minced texture diet and nutritional supplement at every meal. Resident had been receiving a nutritional supplement for a long time and had tolerated it.

The licensee failed to ensure that residents #005 and #021 received the care set out in the written plan of care, related to provision of the appropriate diet order and eating assistance, respectively. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (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, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Medication policy is complied with.

A complaint Log #002871-18 was received on an identified date, involving resident #001 related to medication administration.

As part of the medication management program under O. Reg 79/10, s. 114 (2) the licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

Review of the Medication policy, LTC-CA-WQ-200_06-01 was completed by inspector #194 indicated:
8. k. - Return to the medication cart and sign for the administration of each medication given before proceeding to the next resident. Where medications are refused or held, use appropriate numbered code on MAR sheet and chart on progress notes.

During an medication observation completed by inspector #194 on an identified date, RPN #102 was observed signing medications on the Electronic Medication Administration Records (E-MARS) that were previously administered.

During the course of the interview on an identified date and time, RPN #102 confirmed having previously administered medications to residents that had not been signed at the time of administration, stating that the computer was too slow. RPN #102 indicated that

signing of the administered medication would be completed after the medication pass.

A Medication Audit Report on an identified date was reviewed by inspector #194. The report identified that 27 residents in two separate home areas and 9 residents in another home area were administered their medications outside the 1 hour timeline for administration.

Resident #012 was scheduled to receive medications at a specific time and were signed by RPN #102 as being administered, 1 hour and 14 min late.

Interview with resident #012 was conducted by inspection #194 on an identified date. Resident #012 indicated receiving medications before the meal, on the identified date. Resident #012 expressed always receiving medications prior the the identified meal. Resident #012 did not have any voiced concerns related to medication administration.

Resident #013 was scheduled to receive medications at a specific time, and were signed by RPN #102 as being administered 1 hour and 39 min late.

Interview with resident #013 was conducted by inspector #194 on an identified date. Resident #013 indicated that medications were administered on an identified date before a meal. Resident #013 did not have any concerns related to medication administration.

Resident #015 was scheduled to receive medications at a specific time and were signed by RPN #102 as being administered, 1 hour and 33 min late.

The licensee failed to comply with the Medication Administration policy LTC-CA-WQ-200-06-01 when RPN #102 administered medications for resident #012, #013 and #015 and did not sign as being administered in the Electronic Medication Administration Record when administered as directed in the policy. [s. 8. (1) (b)]

Issued on this 28th day of May, 2018

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

Original report signed by the inspector.