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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Amended Public Copy/Copie modifiée 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
Apr 15, 2020	2020_715672_0004 (A1)	021707-19, 021737-19, 002711-20	Critical Incident System

Licensee/Titulaire de permis

Chartwell Master Care LP
7070 Derry Crest Drive MISSISSAUGA ON L5W 0G5

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

Chartwell Bon Air Long Term Care Residence
131 Laidlaw Street South Cannington ON L0E 1E0

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended due to a licensee change for Chartwell Bon Air Long Term Care Residence effective April 1, 2020. The compliance order will be inspected with the new licensee Bon Air Long Term Care Residence, which is newly owned by DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc., and managed by Responsive Health Management Inc.. There were no other amendments made to the report outside of Compliance Order #001.

Issued on this 15th day of April, 2020 (A1)

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

Original report signed by the inspector.

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended 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): February 18, 20, 21 and March 2, 2020

The following intakes were inspected during this Critical Incident System inspection:

One intake related to a critical incident report regarding a resident fall with injury.

One intake related to a critical incident report regarding an allegation of staff to resident abuse.

One intake related to a critical incident report regarding an incident of incompetent treatment of a resident.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Physicians, family members, residents and visitors to the home.

During the course of the inspection, the inspector(s) reviewed health care records, observed residents, reviewed employee training records, schedules and the following policies: Falls Prevention Program, Zero Tolerance of Resident Abuse and Neglect, Internal Investigations, Medication Administration via specified devices, Enteral Feeding – specified devices, Three Month Medication Reviews, and Readmission of Resident from LOA, Hospital or Other

The following Inspection Protocols were used during this inspection:

Falls Prevention
Hospitalization and Change in Condition
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of the original inspection, Non-Compliances were issued.
6 WN(s)
4 VPC(s)
1 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 medications were administered to residents in accordance with the directions for use specified by the prescriber.

A Critical Incident Report was submitted to the Director related to an incident of improper/incompetent treatment of resident #001 by RPN #102. The CIR indicated that on a specified date, resident #001 was transferred to the hospital for replacement of the identified device. The resident returned to the home with a new device. On a later specified date, resident #001 was transferred back to the hospital, as they were observed to be exhibiting identified symptoms. Resident #001 was admitted to the hospital and received a diagnosis which required a specified intervention.

During review of the internal investigation notes, Inspector #672 noted the hospital had informed the licensee that resident #001's device had been found in an identified condition. The notes further indicated that when resident #001 had returned from the initial hospital visit, they had arrived with a different device than they had previously, without any information or supplies provided by the hospital. When RPN #102 provided a specified intervention on the identified date, they did not utilize the device properly. During shift report that day, RPN #102 demonstrated to RPN #107 how they had utilized resident #001's device. Prior to implementing an identified intervention for resident #001, RPN #107 conferred with RN #106, and found that indeed the device had been incorrectly utilized by RPN #102, but did not report this to the Administrator, Registered Dietitian or physician.

Inspector #672 reviewed resident #001's physician's orders and electronic Medication Administration Record (eMAR) from an identified period of time, which indicated the resident had specified orders related to the device.

During review of resident #001's progress notes from an identified period of time, Inspector #672 noted that resident #001 had a decline in health status and

exhibited identified symptoms. On an identified date and time, resident #001 was noted to have ongoing episodes of identified symptoms and resident #001 was transferred to the hospital for further assessment. Resident #001 was admitted to the hospital, diagnosed with an identified condition and received a specified intervention.

During the inspection, RPN #102 was unavailable for interview.

During an interview, RPN #107 indicated they were informed by RPN #102 during shift report that RPN #102 had utilized resident #001's device in a specified manner. RPN #107 further indicated they had informed RN #106 of what RPN #102 had reported when they requested further guidance related to how to properly utilize resident #001's device, but had not reported to management or the physician.

During an interview, RN #106 indicated they had not informed management, the registered dietitian or the physician of the possibility of RPN #102 utilizing resident #001's device incorrectly, as they did not have direct knowledge that this had occurred.

During an interview, RN #101 indicated they were informed of resident #001's return to the home by RPN #102, when the RPN was experiencing difficulty with accessing the resident's device. RN #101 further indicated they assisted RPN #102 with preparing the device, but then left the room prior to RPN #102 accessing the device for an identified reason, therefore was not aware that the resident's device had been utilized incorrectly.

During an interview, the Administrator indicated they initiated an internal investigation. The result of the internal investigation was the finding that resident #001's specified interventions were not administered in accordance with the directions for use specified by the prescriber, as RPN #102 had utilized the resident's device incorrectly. Lastly, the Administrator indicated the licensee had electronic policies and procedures related to the device, which included directions regarding how to access and utilize the device. The expectation in the home was for all registered staff to be familiar with the internal policies and procedures related to the device prior to accessing and utilizing a resident's device and if they were unsure of the process, they should reach out to other registered staff members, the registered dietitian, nurse practitioner, physician or hospital and not proceed until they were confident in the correct procedure.

The licensee failed to ensure that identified interventions were administered to resident #001 in accordance with the directions for use specified by the prescriber when RPN #102 utilized the resident's device incorrectly. [s. 131. (2)]

Additional Required Actions:

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés: CO# 001

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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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 staff collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

A Critical Incident Report was submitted to the Director related to resident #001 being admitted to the hospital and diagnosed with an identified condition, after their device had been utilized incorrectly by a registered staff member.

During record review, Inspector #672 reviewed the licensee's internal policy related to the identified device, which provided instructions and guidance related to the usage of the device and who to contact and when if the resident exhibited specified symptoms.

During review of the internal investigation notes, Inspector #672 noted the hospital had informed the licensee that resident #001's device had been found in an identified condition. The notes further indicated that when resident #001 had returned from the initial hospital visit, they had arrived with a different device than they had previously, without any information or supplies provided by the hospital. When RPN #102 provided a specified intervention on the identified date, they did not utilize the device properly.

During review of resident #001's progress notes from an identified period of time, Inspector #672 noted that on a specified date and time, RPN #107 administered an identified medication, as resident #001 was noted to have specified symptoms. During the identified period of time, resident #001 continued to present with specified symptoms. Resident #001 received several doses of identified medications, some of which were deemed to be ineffective, as resident #001 continued to present with specified symptoms. The progress notes further indicated the physician was not notified of resident #001's condition until an identified date and time, when they were informed resident #001 had been experiencing specified symptoms and resident #001 was transferred to the hospital for further assessment. Resident #001 was admitted to the hospital and diagnosed with an identified condition. There was no documentation to indicate the physician was informed of resident #001's condition during the identified period of time, or that the registered dietitian was informed of resident #001's condition.

During the inspection, RPN #102 and registered dietitian #115 were unavailable for interview.

During separate interviews, RPN #107 and RNs #101 and #106 indicated they had worked several shifts when resident #001 was exhibiting multiple episodes of specified symptoms. RPN #107 and RNs #101 and #106 further indicated were

not aware of the requirement for the physician or registered dietitian to be informed of the resident's condition if the resident was exhibiting episodes of specified symptoms, as directed within the internal device policy, as they had not received education/training on the policy.

During an interview, MD #114 indicated they were the most responsible physician for resident #001. MD #114 further indicated they were unaware of the possibility that resident #001's device had been utilized incorrectly until after resident #001 returned to the home from the hospital. MD #114 indicated they relied on the registered staff in the home to contact them when a resident began to exhibit symptoms. MD #114 further indicated they relied on the registered staff to also include all relevant information when providing resident updates.

During an interview, the Administrator indicated the expectation in the home was for all registered staff to be familiar with the internal policy and procedure prior to utilizing a device and if they were unsure of the process, they should reach out to other registered staff members, the registered dietitian, nurse practitioner, physician or hospital and not proceed until they were confident in the correct procedure. The Administrator further indicated the registered staff members were expected to provide updates to the physician or other members of the multidisciplinary team as required by the resident's health condition or as directed within internal policies. The updates were to include all relevant information required by the physician or other health care professional in order to make informed decisions regarding the care of the resident. The Administrator indicated the registered staff members had not collaborated with the physician or registered dietitian as outlined in the internal policy, regarding resident #001's health condition.

The licensee failed to ensure the registered staff collaborated with the physician and registered dietitian in the assessment of resident #001 so that their assessments were integrated, consistent with and complemented each other, when the resident presented with identified symptoms. [s. 6. (4) (a)]

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

A Critical Incident Report (CIR) was submitted to the Director related to a fall sustained by resident #002, which resulted in the resident being transferred to the hospital and diagnosed with an identified injury. The CIR indicated that resident

#002 was at increased risk for falling and had sustained previous falls within the last 90 days. The CIR further indicated that resident #002 had a history of self transferring and toileting independently, therefore required an identified fall prevention intervention. At the time of the fall, resident #002 was observed to have self transferred, toileted independently and fell while transferring from the toilet. When resident #002 was found on the floor of the bathroom, the identified fall prevention intervention was noted to not be functional. The licensee indicated an internal investigation would be completed as to why the identified fall prevention intervention had not been functioning at the time of the fall.

During record review, Inspector #672 noted resident #002 was at high risk for falling and had several interventions in place as fall prevention strategies. Inspector #672 reviewed resident #002's progress notes and noted there were multiple incidents where resident #002 was found by staff to have self transferred and toileted independently, therefore staff were to remain with resident #002 at all times while in the bathroom. The progress note and post fall assessment from the specified date indicated resident #002's identified fall prevention intervention had not been functioning at the time of the fall.

During resident observations, Inspector #672 observed that resident #002 had an identified intervention in place, but it did not appear to be functional. Inspector #672 reported this to PSW #104. On an identified date and time, PSWs #108 and #109 toileted the resident, prior to returning resident #002 to the bed. While resident #002 was being toileted, both staff members stepped out of the bathroom for an identified period of time. While resident #002 was in the bathroom alone, they called out for assistance, which was not heard by either staff member, therefore Inspector #672 informed both PSWs that resident #002 was calling out for assistance. PSWs #108 and #109 entered the bathroom, assisted resident #002 with personal hygiene and then returned resident #002 to bed.

During further resident observations, Inspector #672 again observed that resident #002 had an identified fall prevention intervention in place, but it did not appear to be functional. Inspector #672 reported this to PSWs #108 and #109. PSWs #108 and #109 tested the identified fall prevention intervention and found it to be non-functional. This was reported to RN #106, who instructed the PSW staff to find a replacement for the identified intervention.

During separate interviews, PSWs #108 and #109, RPN #107 and RN #106 indicated the expectation in the home was for staff to test all identified devices

and interventions prior to each usage, to ensure it was functional. PSWs #108 and #109 indicated they had not tested resident #002's fall prevention intervention at all during the shift, for an identified reason. RN #106 indicated on the date of resident #002's fall, the fall prevention intervention was observed to be not functioning, which was reported to the Administrator.

During an interview, the Administrator indicated the expectation in the home was for staff to test all identified devices and interventions prior to each usage, to ensure they were functional. The Administrator further indicated all front-line nursing staff received training on how to use each of the fall prevention interventions available in the home. Lastly, the Administrator indicated resident #002 had not received care as specified in their plan of care on the date of resident #002's fall, or the dates of the resident observations conducted by Inspector #672, as the plan directed staff to ensure the intervention was implemented every time the resident was in bed; and on the identified date when the resident was left alone in the bathroom space.

The licensee failed to ensure that care was provided to resident #002 as specified in the plan when resident #002 was left in bed without a functional fall prevention intervention and on the identified date when the resident was left alone in the bathroom for an identified period of time. [s. 6. (7)]

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 staff collaborate with each other in the assessment of the residents so that their assessments are integrated, consistent with and complement each other and that the care set out in the plan of care was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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 where the Act or this Regulation required 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 was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

According to LTCHA, 2007. O. Reg. 79/10, r. 68 (1) (b) The nutrition care and hydration program is a required organized program of hydration required under clause 11 (1) (b) of the Act. O. Reg. 79/10, s. 68 (1).

During record review, Inspector #672 reviewed the internal policy related to the identified device, which provided instructions and guidance related to the usage of the device and where/how the registered staff were expected to document on the usage of the device.

A Critical Incident Report was submitted to the Director related to resident #001 being admitted to the hospital and diagnosed with an identified condition and their device had been utilized incorrectly by a registered staff member.

During review of the internal investigation notes, Inspector #672 noted the hospital had informed the licensee that resident #001's device had been found in an identified condition. The notes further indicated that when resident #001 had returned from the initial hospital visit, they had arrived with a different device than they had previously, without any information provided by the hospital. When RPN

#102 provided a specified intervention on the identified date, the device was not utilized properly.

During record review, Inspector #672 reviewed the specified forms the internal policy indicated were expected to be used related to the usage of resident #001's device and noted the forms had not been completed during an identified time period.

During separate interviews, RPN #107, RNs #101, #106 and #110 indicated the specified forms had not been completed during an identified period of time, at the direction of the DOC.

During an interview, the DOC indicated they had provided direction to the registered staff that the specified forms were not required to be completed by the registered staff. The DOC further indicated the directions on the other document (s) the registered staff completed did not encompass all of the required information related to the usage of resident #001's device and had been unaware that the policy directed the specified form was to be used.

During an interview, the Administrator indicated they had been unaware the specified forms were not being used by the registered staff to document for resident #001 related to the usage of the identified device until the internal investigation was conducted into the incident with RPN #102 and resident #001’s device. Once they realized the forms were not being used, direction was immediately provided to the registered staff to initiate usage of the forms, as they were aware the internal policy directed the form was to be used for all residents who utilized the identified device. The Administrator further indicated staff were not following the internal policy regarding documentation related to usage of the identified device.

2. During record review, Inspector #672 reviewed the licensee's internal policy related to the identified device, which provided instructions and guidance related to the usage of the device. The policy further directed that residents with the medical device were expected to receive medications one at a time, with interventions implemented between each medication administration.

During separate interviews, RPN #107, RNs #101, #106 and #110 indicated that during an identified period of time when resident #001 was present in the home with a new medical device, staff did not have the appropriate supplies required to

access the device. When resident #001 returned from the hospital following the incident with RPN #102, supplies were sent with the resident, so staff then began using the supplies sent from the hospital.

During record review, Inspector #672 reviewed the hospital transfer notes and prescriptions. The hospital transfer summary indicated the resident was sent back to the home with the required supplies and directions for the proper usage of the medical device.

During resident observations, Inspector #672 observed resident #001 receive medications from RPNs #107, #116 and #117. During each medication administration, all medications appeared to be mixed and administered together.

During separate interviews, RPNs #107, #116 and #117 indicated it was routine practice for resident #001 to receive all medications mixed together, in order to save time.

During an interview, the Administrator indicated the expectation in the home was for staff to follow all internal policies and procedures and administer medications according to the directions listed within the internal policies.

The licensee failed to ensure the internal policy related to usage of the medical device was complied with, when staff did not utilize the identified documentation forms and when staff did not administer medications for resident #001 according to the instructions listed. [s. 8. (1) (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 where the Act or this Regulation required 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 is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy which promoted zero tolerance of abuse and neglect of residents was complied with.

During record review, Inspector #672 reviewed the internal policy related to zero tolerance of resident abuse and neglect which indicated that every staff member who was aware of an alleged incident of abuse or neglect of a resident must immediately report the allegation. The policy also outlined the definitions of each type of resident abuse and neglect and that staff members were to be educated on the policy at a minimum of upon hire and annually thereafter.

A Critical Incident Report was submitted to the Director related to an allegation of staff to resident abuse which occurred between PSW #113 and resident #003. The CIR indicated that during a specified change round, PSW #103 observed PSW #113 engage in an act of a specified type of abuse of resident #003.

During record review, Inspector #672 noted that the alleged incident between PSW #113 and resident #003 occurred at an identified time and PSW #103 did not report the incident to the shift charge nurse. The internal investigation notes

indicated PSW #103 informed RN #101, the following shift charge nurse, of the alleged incident during a conversation following the end of the shift, while gossiping about what had occurred. During review of the Point of Care (POC) documentation, Inspector #672 noted that PSW #113 provided personalized resident care to multiple residents following the alleged incident between PSW #113 and resident #003.

During the inspection, PSWs #103 and #113 were not available for interviews.

During an interview, RN #101 indicated they were informed of the allegation of staff to resident abuse from PSW #103, after shift report had occurred, while PSW #103 was preparing to leave the home and was gossiping about what had occurred between PSW #113 and resident #003. RN #101 further indicated they inquired why PSW #103 had not reported the incident to their shift charge nurse, but PSW #103 had not provided any rationale. After being informed of the allegation, RN #101 reported the allegation to the Administrator approximately three hours later. RN #101 indicated PSW #113 had provided resident care to several residents independently following the alleged incident with resident #003. RN #101 further indicated the expectation in the home was for staff to immediately report any allegation of resident abuse or neglect to the shift charge nurse, as per the directions outlined in the internal prevention of resident abuse and neglect policy, which every staff member in the home had received education and training on, during the annual mandatory education sessions related to the prevention of resident abuse and neglect.

During an interview, the Administrator indicated they became aware of the allegation of staff to resident abuse between PSW #113 and resident #003 from RN #101. The Administrator further indicated PSW #113 was a PSW provided to work in the home from a staffing agency but had worked in the home multiple times in the past and had received education and training on the internal prevention of resident abuse and neglect policies and procedures, along with PSW #103. The Administrator indicated the expectation in the home was for all staff members to report any allegation of resident abuse or neglect to the shift charge nurse or a member of the management team immediately following the incident. Once an allegation was brought forward, the staff member involved would be removed from the home to prevent further interactions with the residents, until an internal investigation could be completed. Lastly, the Administrator indicated the internal policy which promoted zero tolerance of abuse and neglect of residents had not been complied with, when PSW #103 did not

immediately report the allegation of staff to resident abuse between PSW #113 and resident #003.

The licensee failed to ensure that the written policy which promoted zero tolerance of abuse and neglect of residents was complied with, when PSW #103 did not immediately report an allegation of staff to resident abuse between PSW #113 and resident #003. As a result of PSW #103 not immediately reporting the allegation, PSW #113 went on to provide personal care and toileting independently to multiple residents, following the incident with resident #003. [s. 20. (1)]

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 written policy which promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a documented reassessment of each resident's drug regime completed at least quarterly.

A Critical Incident Report was submitted to the Director related to resident #001 being admitted to the hospital and diagnosed with an identified condition and their device had been utilized incorrectly by a registered staff member.

During review of the internal investigation notes, Inspector #672 noted the hospital had informed the licensee that resident #001's device had been found in an identified condition. The notes further indicated that when resident #001 had returned from the initial hospital visit, they had arrived with a different device than they had previously, without any information or supplies provided by the hospital. When RPN #102 provided a specified intervention on the identified date, they did not utilize the device properly.

During record review, Inspector #672 reviewed the hospital transfer notes and prescriptions. The hospital transfer summary indicated the resident was admitted to the hospital, received identified interventions and was transferred back to the home with identified prescriptions and directions for the home to review the policies and procedures related to the medical device with the long-term care home staff.

Inspector #672 reviewed the physician orders for resident #001 and noted resident #001's quarterly medication review was for an authorized period of time but had not been reviewed and signed by the registered staff and physician until after the authorized period had begun.

Inspector #672 then reviewed the internal policy related to quarterly medication reviews which stated the physician was responsible to complete the quarterly medication reviews in a timely manner and prior to the start of the authorized time period.

During separate interviews, RNs #101 and #106 indicated it was a routine practice in the home for the physician to complete the quarterly medication reviews at some time during the initial month of the medication review, but was

not completed prior to the beginning of the quarter.

During an interview, the Administrator indicated they were aware of the practice in the home of the physician completing the quarterly medication reviews at some time during the initial month of the medication review, but not being completed prior to the beginning of the quarter. The Administrator then reviewed the internal policy related to quarterly medication reviews and indicated the expectation in the home was for the quarterly medication reviews to be completed prior to the initiation of the initial month of the three month medication review. The Administrator further indicated following the review of the internal medication review policy that resident #001 had technically received medications from an identified period of time without a current physician's order, due to failing to ensure a reassessment of resident #001's drug regime was completed at least quarterly.

The licensee failed to ensure that a reassessment of resident #001's drug regime was completed at least quarterly, when the three month medication review for the authorized period was not reviewed and signed until after the beginning of the quarter. [s. 134. (c)]

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 a documented reassessment of each resident's drug regime is completed at least quarterly, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was notified no later than one business day after the occurrence of an incident that resulted in a significant change in the resident's health condition for which the resident was taken to hospital.

A Critical Incident Report was submitted to the Director related to resident #001 being admitted to the hospital and diagnosed with an identified condition and their device had been utilized incorrectly by a registered staff member.

During review of the internal investigation notes, Inspector #672 noted the hospital had informed the licensee that resident #001's device had been found in an identified condition. The notes further indicated that when resident #001 had returned from the initial hospital visit, they had arrived with a different device than they had previously, without any information or supplies provided by the hospital. When RPN #102 provided a specified intervention on the identified date, they did not utilize the device properly.

During record review, Inspector #672 reviewed resident #001's progress notes from an identified period of time which indicated resident #001 exhibited specified symptoms. Resident #001 was transferred to the hospital and admitted for specified interventions related to their diagnosis and medical device. The progress notes indicated the hospital contacted the home to provide an update on resident #001's condition and inform the home that the medical device had been utilized incorrectly.

During an interview, the Administrator indicated they were informed of the incident on an identified date, as they had been away from the home during the previous week. The Administrator further indicated they had returned to the home the day

prior to the date they were informed. The Administrator indicated the DOC had been aware of the incident involving resident #001 on the day the resident returned to the home from hospital but had decided not to initiate an internal investigation or notify the Director until the Administrator returned to the home the following week. The Administrator further indicated they and the DOC were both aware of the legislative requirements regarding initiation of internal investigations and notification of the Director, therefore the DOC should have immediately initiated an internal investigation and then notified the Director within one business day of becoming aware of the incident.

The licensee failed to ensure the Director was notified within one business day after being notified by the hospital that resident #001 had sustained a specified condition and the medical device had been incorrectly utilized by a staff member. [s. 107. (3) 4.]

Issued on this 15th day of April, 2020 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2020_715672_0004 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021707-19, 021737-19, 002711-20 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Apr 15, 2020(A1)
Licensee / Titulaire de permis :	Chartwell Master Care LP 7070 Derry Crest Drive, MISSISSAUGA, ON, L5W-0G5
LTC Home / Foyer de SLD :	Chartwell Bon Air Long Term Care Residence 131 Laidlaw Street South, Cannington, ON, L0E-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Rodrigues

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

(A1)
The following order(s) have been rescinded / Le/les ordre(s) suivants ont été annulés:

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 15th day of April, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by JENNIFER BATTEN (672) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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Service Area Office / Bureau régional de services : Central East Service Area Office