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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 26, 27, 2019	2019_725522_0001	001979-19	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 Aylmer Long Term Care Residence
465 Talbot Street West AYLMER ON N5H 1K8

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

JULIE LAMPMAN (522)

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): March 14, 15, and 18, 2019.

This complaint inspection was related to alleged negligent care by staff.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Registered Nurses, Registered Practical Nurses, a Personal Support Worker, a Physician and a Laundry Aide.

The inspector also reviewed resident clinical records, the home's complaints log, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were not neglected by the licensee or

staff.

Long-Term Care Homes Act, 2007 defines neglect as "The failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

1) A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

The complainant forwarded email correspondence they had with the Director of Care (DOC) at Chartwell Aylmer. The complainant stated in the email to the DOC that they were concerned that the identified resident had a significant change in condition and the registered staff had failed to complete an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

The DOC responded to the complainant's email and acknowledged that the registered staff had not completed an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

A review of the identified resident's hard copy chart noted the resident was admitted to the home on a specific date.

A) A review of the identified resident's New Admission/Move-in Order and Information Form dated the resident's date of admission, noted that the identified resident had a specific diagnosis that was managed by a specific medication. There was a hand written order to continue a specific dosage of the specific medication. The applicable medication sources/lists referenced were noted as "CCAC/Resident Assessment Instrument" and "Family/Resident List."

A review of the identified resident's hard copy chart noted a Community Care Access Centre (CCAC) -Resident Assessment Instrument (RAI), a hospital discharge record and a patient medication profile from the identified resident's pharmacy. The three documents noted that the resident received a lower dosage of the specified medication than that specified on the identified resident's New Admission/Move-in Order and Information Form.

In a telephone interview, a Registered Nurse (RN) stated they had completed the identified resident's admission orders using the CCAC-RAI and they had spoken with the identified resident's family. Inspector reviewed the CCAC-RAI, the hospital discharge record and the patient medication profile from the identified resident's pharmacy with the RN. Inspector inquired why the RN had indicated on the identified resident's New Admission/Move-in Order and Information Form that the identified resident was to continue to receive a higher dosage of the specific medication than what was indicated on the documents. The RN stated they couldn't recall why there was a difference in the identified resident's admission order compared to the medication sources available on admission.

In an interview, a Registered Practical Nurse stated they completed the first check of the identified resident's admission orders. The RPN stated they would have done the check to ensure what was on the doctor's orders matched what was electronically in the computer in the identified resident's electronic Medication Administration Record (eMAR). The RPN stated they generally do not review any admission documents when completing the first or second check of a resident's admission orders. The RPN stated they would only review documents related to medication if they were initiating the admission orders.

In a telephone interview, the Physician stated they were the identified resident's attending physician and would have approved the identified resident's admission orders verbally over the phone. The Physician stated usually the registered staff would call them with the new orders for an admission. The Physician stated they would not make any changes to what a resident was already receiving, therefore they had continued the order for the higher dosage of the specific medication for the identified resident as this was what registered staff indicated that the identified resident was receiving. The Physician stated usually they do not double check the orders against the admission documents provided for a resident as the nurse would do this.

In an interview, the Director of Care reviewed the identified resident's hard copy file and compared the admission documents against the New Admission/Move-in Order and Information Form. The DOC stated they could not understand why there was a discrepancy in the identified resident's ordered medication. The DOC reviewed the resident's electronic file and noted a Ministry of Health and Long-Term Care Health Assessment dated two years earlier, which indicated the identified resident was on a higher dosage of the specific medication. The DOC stated the RN completing the

completing the medication reconciliation.

The DOC stated the registered staff who completed the first and second check of the identified resident’s admission orders should have checked to see that the orders were accurate to begin with. The DOC stated the registered staff should have gone through the same paper work that the registered nurse went through to create the orders and made sure everything was there and that nothing was missed.

B) Further review of the identified resident’s New Admission/Move-in Order and Information Form noted the identified resident was to have specific testing completed daily and this was to be reassessed in two weeks.

A review of the identified resident’s electronic and hard copy file noted the specific testing was stopped after two weeks and there was no documentation to support that the specific testing and results of the tests were ever reassessed as per the physician’s orders.

A review of the identified resident’s care plan noted the resident had a specific diagnosis and staff were to monitor specific symptoms related to the resident’s diagnosis. The care plan also noted that specific testing should be completed as per the physician’s order and specific results were to be reported to the physician.

Review of the identified resident’s electronic progress notes noted on a specific date, approximately one month after the specific testing was to be reassessed, the identified resident had a significant change in condition. Registered staff failed to assess the resident appropriately considering symptoms of the identified resident’s disease diagnosis and complete specific testing on the identified resident. It was not until approximately eight hours after the identified resident had the significant change in condition that the registered staff on duty at that time completed an appropriate assessment, which included a specific test and put appropriate interventions in place for the identified resident. After this, the identified resident returned to their previous level of functioning.

Review of the home’s policy related to a specific disease diagnosis noted that when a resident was admitted to the home with a specific diagnosis the resident’s admission orders would include the frequency of specific testing. The policy stated that the specific testing should be completed upon administration of specific medication unless otherwise ordered by the physician.

Review of the home's policy related to symptoms of a specific disease diagnosis noted when a resident displays specific symptoms, specific testing should be performed immediately.

In an interview, a Registered Nurse (RN) stated they were aware that the identified resident was on a specific medication. Upon reviewing the identified resident's electronic and hard copy file with the Inspector, the RN confirmed that registered staff stopped completing specific testing on the identified resident two weeks after the specific testing was ordered. The RN stated they would leave the reassessment of the specific testing up to the resident's physician to reorder. The RN confirmed that there was no documentation in the identified resident's electronic and hard copy chart regarding a reassessment of the identified resident's specific testing and the results of those tests.

The RN stated they were the registered staff in charge on a specific date and they had been called to assess the identified resident, as the resident had a change in condition. The RN stated they completed a set of vital signs on the identified resident but did not complete specific testing. The RN stated they should have completed specific testing on the identified resident when the resident had a change in condition, and they failed to do so.

In a telephone interview, a Registered Practical Nurse (RPN) stated they were working days in the home on a specific date. The RPN stated they were asked by another RPN to assess the identified resident, as the resident had a change in condition. The RPN told the other RPN that this was a change for the identified resident. The RPN stated at the time, specific testing was not completed on the identified resident. The RPN stated they knew that they should have completed specific testing on the identified resident, as the resident had a specific diagnosis and had a change in condition.

The RPN stated when the identified resident's specific tests were to be reassessed after two weeks, registered staff should have made a note for the physician on the doctor's board, and probably noted that the identified resident was refusing the tests. The RPN stated that registered staff probably forgot to document the reassessment in the identified resident's progress notes.

In a telephone interview, a RPN stated they provided care to the identified resident on the specific date. The RPN stated when they saw the identified resident, they thought the identified resident was deteriorating. The RPN stated they had not seen the identified

resident in a couple of days and asked another RPN to assess the identified resident. The RPN stated the RN also assessed the identified resident. The RPN stated they should have completed specific testing on the identified resident, and they did not.

In an interview, a RPN stated they provided care to the identified resident on a specific shift. The RPN stated the identified resident had a significant change in condition. The RPN stated due to the fact the identified resident had a specific diagnosis and received specific medication they decided to complete a specific test on the resident. Due to the result of the specific test the RPN provided the identified resident with appropriate interventions and the resident returned to their usual self.

The RPN stated if specific testing for the identified resident was to be reassessed after two weeks, this should have been put on the doctor's board for the physician to reassess. The RPN stated the registered staff did have a discussion and questioned why the identified resident did not have specific testing ordered.

In a telephone interview, the Physician stated they were the attending physician for the identified resident. The Physician stated if the identified resident was to have specific testing reassessed in two weeks the nurse would usually record this on the doctor's board or call the doctor. The Physician stated they did not keep the notes from the doctor's board that they were left in the home. The Physician stated that if they reassessed the specific testing for the identified resident then they would have documented this in the identified resident's progress notes. Inspector informed the Physician that there was no documentation from registered staff or the physician related to a reassessment of the specific testing for the identified resident. The Physician and Inspector reviewed the identified residents specific test results for an identified two week period. The Physician stated registered staff should have let them know that the specific testing for the identified resident needed to be reordered.

The Physician stated they recalled being called by registered staff on the specific date, about the identified resident's change in condition. Inspector inquired why the Physician had not ordered specific testing for the identified resident. The Physician stated their instruction was always to check vitals. The Physician stated vitals would include blood pressure, heart rate, respirations, oxygen and specific testing if the resident had a specific disease diagnosis.

In an interview, the Director of Care (DOC) stated when the specific testing for the identified resident was to be reassessed after two weeks that this would generally go on

the doctor's board for reassessment. The DOC stated registered staff may not necessarily document in the resident's progress notes the outcome of the reassessment but that it would be good nursing practice to document the reassessment. The DOC stated they would expect the physician to be aware that the specific testing for the identified resident needed to be reassessed and then follow up. The DOC stated they did not keep records in the home of the notes from the doctor's board.

The DOC stated they were aware of the change in condition for the identified resident. The DOC stated they would expected registered staff to have a collaborative discussion on what measures they needed to take when the identified resident had a change in condition. The DOC stated they would have expected there to be some discussion that the identified resident had a specific diagnosis and was on a specific medication and the registered staff should complete specific testing on the identified resident and get an order if they had to.

The DOC stated after they had received a complaint regarding the care provided to the identified resident, they spoke with the registered staff and determined that staff had failed to complete specific tests on the identified resident when the identified resident had a change in condition.

The DOC stated they sent an email to all registered staff regarding completing thorough assessments when a resident has a significant change in health status.

The registered staff and physician failed to provide the identified resident, with the treatment and care required, this pattern of inaction jeopardized the health of the identified resident. Registered staff failed to complete the appropriate checks for the identified resident when completing the identified resident's admission orders, resulting in the identified resident being ordered a significantly higher dose of a specific medication. Registered staff and the Physician did not ensure specific testing for the identified resident was reassessed after two weeks as specified in the identified resident's admission order. When the identified resident had a significant change in condition on a specific date, registered staff failed to complete specific testing on the identified resident, and assess the identified resident for symptoms of their disease diagnosis. It wasn't until eight hours after a documented change in the identified resident, that specific testing was completed on the identified resident and appropriated interventions were put in place for the identified resident.

2) Another identified resident was admitted to the home on a specific dated, with a

specific diagnosis, which required specific medication.

Review of the identified resident's electronic progress notes noted on a specific date the physician ordered one of the medications for the specific disease diagnosis to be put on hold, specific testing was to be completed and the physician was to be notified if the test results were within a specific range. These orders were to be reassessed in two weeks.

On two occasions, the identified resident's test results were within a specific range. There was no documentation in the identified resident’s progress notes to support that the physician was notified, as per the physician’s orders. No further testing was documented after the two week period. There was no documented reassessment of the specific testing for the identified resident and the resident’s medication remained on hold.

Further review of the identified resident’s progress notes noted that approximately one month after the specific testing was stopped and the medication was put on hold, the family requested the identified resident to have the specific testing completed as they felt the identified resident was not themselves. The specific testing noted that the results for the identified resident were higher than normal, after the specific testing was completed several times, the identified resident was ordered new medication and the specific testing was reordered.

In an interview, a Registered Nurse (RN) stated if the specific testing was only for two weeks then they would leave the follow-up with the physician. The RN stated they would make a note for the doctor that the specific testing needed to be reassessed.

In an interview, a Registered Practical Nurse stated they would make a note for the doctor if specific testing for a resident needed to be reassessed.

In a telephone interview, the Physician stated they rely on the registered staff to let them know if a resident needs to be reassessed and orders continued. The Physician stated if this happened then it would be documented in the resident’s progress notes.

In an interview, the Director of Care stated that they would expect to see that it was documented in the identified resident’s progress notes that staff called the doctor when the specific testing for the identified resident noted the results fell within a specific range, as per the doctor’s orders. The DOC stated they thought the order for the specific testing would automatically come off the eMAR after the two weeks if there was no reassessment or changes to the order. The DOC stated they would expect both the

doctor and the registered staff to follow up regarding the specific testing for the identified resident after the identified resident's medication was put on hold.

The registered staff and physician failed to provide the identified resident with the treatment and care required, this pattern of inaction jeopardized the health of the identified resident. The Physician put the identified resident's specific medication on hold and ordered specific testing two days per week for two weeks with a request to be notified if the identified resident's test results were within a specific range. On two occasions the identified resident had documented test results that were within the specific range and the physician was not notified. After the two week period registered staff stopped the specific tests on the identified resident and the resident's medication remained on hold. There was no documentation by registered staff or the physician to indicate that the identified resident had been reassessed and there had been a discussion regarding the identified resident's test results and discontinuation of the specific tests and medication for the identified resident. It was not until the identified resident's family requested that staff complete a specific test on the identified resident, that it was determined that the results for the specific test were higher than normal. The identified resident was then put on a specific medication and specific testing was reordered.

The licensee has failed to ensure that residents were not neglected by the licensee or staff. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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 :

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

1) Ontario Regulation 79/10, r. 114 (2) states, “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.”

A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

A review of the identified resident’s hard copy chart noted the resident was admitted to the home on a specific date, with an admission order of a specific dose of a medication.

In an interview, the Director of Care (DOC) stated that the home’s Medication Reconciliation policy was a general policy and the Classic Care Pharmacy policy Medication Reconciliation – Long-Term Care Homes, would be the overarching policy that staff would follow.

Review of Classic Care Pharmacy's policy "Medication Reconciliation - Long Term Care Homes” 2.7.1, with a review date of December 2016, noted the following:
“New admission to the Long Term Care Home procedure:
“The nurse creates the Best Possible Medication History (BPMH) from all possible sources, including, but not necessarily limited to:
a. MAR (LTCH/RH, Hospital)

b. CCAC/ Resident Assessment Instrument
c. Discharge List/Prescriptions from hospital
d. Community Pharmacy Medication List
e. Medication Vials/Package
f. Family/Resident list
g. Other"

"The nurse documents all relevant sources used to create the BPMH from the list provided in the upper right hand corner of the form. During this process, it is crucial to compare the orders, monitoring for any discrepencies. If a discrepency is discovered, document the details in the comments section next to the medication order. Resolve any identified discrepencies with the most appropriate health care professional."

"In the usual manner, the nurse contacts the resident's attending physician."

"The physician assesses the nurse prepared medication profile on the Triplicate Medication Reconciliation and Admission Order Form(s) (and any supporting documents as applicable) and provides direction to continue, discontinue or hold each listed medication and documents by checking the appropriate box for each order...Once authorized by the physician, the resultant list becomes the Resident's admission orders and further orders are not permitted to be added to the page(s)."

"The medication orders are first and second checked by two different nurses according to usual routine. Available source documents are reviewed as applicable."

Review of the home's policy "Medication Reconciliation" LTC-CA-WQ-200-06-12, with a review date of December 2017, noted the following:

"On admission Registered Staff will obtain from the resident and family a best possible medication history (BPMH). This history will be reviewed by the physician/nurse practitioner as a component of the admission process and approving the medication regime for the new resident."

A review of the identified resident's New Admission/Move-in Order and Information Form dated the resident's date of admission, noted that the identified resident had a specific diagnosis that was managed by a specific medication. There was a hand written order to continue a specific dosage of the specific medication. The applicable medication sources/lists referenced were noted as "CCAC/Resident Assessment Instrument" and

“Family/Resident List."

The New Admission/Move-in Order and Information Form was signed as a phone order by a Registered Nurse (RN) for the Physician on the identified resident's admission date. "Checking Nurse 1" and "Checking Nurse 2" both signed the form on the identified resident's admission date.

A review of the identified resident's hard copy chart noted a Community Care Access Centre (CCAC) -Resident Assessment Instrument (RAI), a hospital discharge record and a patient medication profile from the identified resident's pharmacy. The three documents noted that the resident received a lower dosage of the specified medication than that specified on the identified resident's New Admission/Move-in Order and Information Form.

In a telephone interview, a Registered Nurse (RN) stated they had completed the identified resident's admission orders using the CCAC-RAI and they had spoken with the identified resident's family. Inspector reviewed the CCAC-RAI, the hospital discharge record and the patient medication profile from the identified resident's pharmacy with the RN. Inspector inquired why the RN had indicated on the identified resident's New Admission/Move-in Order and Information Form that the identified resident was to continue to receive a significantly higher dosage of the specific medication than what was indicated on the documents. The RN stated they couldn't recall why there was a difference in the identified resident's admission order compared to the medication sources available on admission.

The RN stated that the registered staff on evenings would have completed the additional checks of the orders for the identified resident. The RN stated that when registered staff complete the first and second check of the admission orders they do not compare the orders on the New Admission/Move-in Order and Information Form against the medication source documents.

In an interview, a Registered Practical Nurse stated they completed the first check of the identified resident's admission orders. The RPN stated they would have done the check to ensure what was on the doctor's orders matched what was electronically in the computer in the identified resident's electronic Medication Administration Record (eMAR). The RPN stated they generally do not review any admission documents when completing the first or second check of a resident's admission orders. The RPN stated they would only review documents related to medication if they were initiating the

In a telephone interview, the Physician stated they were the identified resident's attending physician and would have approved the identified resident's admission orders verbally over the phone. The Physician stated usually the registered staff would call them with the new orders for an admission. The Physician stated they would not make any changes to what a resident was already receiving, therefore they had continued the order for the higher dosage of the specific medication for the identified resident as this was what registered staff indicated that the identified resident was receiving. The Physician stated usually they do not double check the orders against the admission documents provided for a resident as the nurse would do this.

In an interview, the Director of Care reviewed the identified resident's hard copy file and compared the admission documents against the New Admission/Move-in Order and Information Form. The DOC stated they could not understand why there was a discrepancy in the identified resident's ordered medication. The DOC reviewed the resident's electronic file and noted a Ministry of Health and Long-Term Care Health Assessment dated two years earlier, which indicated the identified resident was on a higher dosage of the specific medication. The DOC stated the RN completing the identified resident's admission orders had referenced the wrong document when completing the medication reconciliation.

The DOC stated the registered staff who completed the first and second check of the identified resident's admission orders should have checked to see that the orders were accurate to begin with. The DOC stated the registered staff should have gone through the same paper work that the registered nurse went through to create the orders and made sure everything was there and that nothing was missed.

2) Long-Term Care Homes Act, 2007, c. 8, s. 21 states, "Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints."

Review of the home's policy "Complaints" LTC-CA-WQ-100-05-09, with a review date of June 2017, noted the following:

"Upon receiving a written complaint the Department Manager will:
i. Inform the Administrator.
ii. Initiate an Investigation Form for the Complaint.
iii. Log all communication with the person who made the complaint with the person's

response on the Complaint Communication Log.
iv. Contact the person who made the complaint acknowledging receipt of the complaint and if necessary obtain additional information to assist with the investigation.
v. Initiate an investigation into the complaint within 24 hours of receipt of the complaint; the complaint will be fully investigated by the Manager – this may include contacting the author of the complaint for further information.
vi. Document the results of your investigation on the Investigation Report form.
vii. Forward the form to the Administrator for response to the author of the complaint."

"The Administrator upon receiving a written complaint will:
i. Notify the Chartwell Director of Regional Operations.
ii. Ontario LTC - Fax a copy of the written complaint to the Duty Inspector on the day the written complaint was received.
iii. Assist the Department Manager with the investigation.
iv. Log all communication with the person who made the complaint with the person's response on the Complaint Communication Log.
v. Review the results of the investigation requesting any clarification of the information provided.
vi. Arrange to meet with the person who filed the complaint to discuss their concerns and the outcome of the investigation into the complaint.
vii. Prepare a written response to the complaint within 10 business days...
viii. Send the response to the author of the complaint."

A complaint was received by the Ministry of Health and Long-Term Care from related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

The complainant forwarded email correspondence they had with the Director of Care (DOC) at Chartwell Aylmer. The complainant stated in the email to the DOC that they were concerned that the identified resident had a significant change in condition and the registered staff had failed to complete an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

The DOC responded to the complainant’s email and acknowledged that the registered staff had not completed an appropriate assessment of the identified resident and provided appropriate interventions immediately when the significant change in condition occurred.

In an interview, the Director of Care stated they had copied the Executive Director (ED) in the response to the complainant so they were aware of the complaint. The DOC stated they had met with the complainant on a specific date, as there was a scheduled care conference for the identified resident that day. The DOC stated they did not have specific documentation related to the investigation into the complaint as they had spoken to the nurses who confirmed they had not completed the specific testing on the identified resident and that was all there was to the investigation.

In an interview, the ED stated they did not have documentation for the complaint investigation for the identified resident. The ED stated normally they would do this, but the care conference happened so quickly. The ED stated the complaint was dealt with at the care conference instead of using the complaint investigation form.

Review of the identified resident's electronic progress notes for the care conference, noted no documentation related to the family's complaint related to the care of the identified resident.

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director.

A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

The complainant forwarded email correspondence they had with the Director of Care (DOC) at Chartwell Aylmer. The complainant stated in the email to the DOC that they were concerned that the identified resident had a significant change in condition and the registered staff had failed to complete an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

The DOC responded to the complainant's email and acknowledged that the registered staff had not completed an appropriate assessment of the identified resident and provided appropriate interventions immediately when the significant change in condition occurred.

In an interview, the Director of Care (DOC) stated that they had copied the Executive Director (ED) on the email response to the complainant as the ED was responsible for following up on complaints.

In an interview, the ED stated they did not forward the complaint to the Director as the home's policy stated it was not necessarily a written complaint if it was an email. The ED stated they did not feel it was a formal complaint, but that the complaint was significant enough that they needed to document it and follow up with the family but not significant enough to pass it on to the Ministry.

The licensee has failed to ensure that a written complaint concerning the care of a resident or the operation of the long-term care home was immediately forwarded to the Director. [s. 22. (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 a written complaint concerning the care of a resident or the operation of the long-term care home is immediately forwarded to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.

A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

The complainant forwarded email correspondence they had with the Director of Care (DOC) at Chartwell Aylmer. The complainant stated in the email to the DOC that they were concerned that the identified resident had a significant change in condition and the registered staff had failed to complete an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

The DOC responded to the complainant's email and acknowledged that the registered staff had not completed an appropriate assessment of the identified resident and provided appropriate interventions immediately when the significant change in condition occurred.

In an interview, the Director of Care (DOC) stated they had not submitted a Critical Incident System (CIS) report related to the improper care of the identified resident. The DOC stated they had looked at the concern more in terms of a complaint.

In an interview, the Executive Director (ED) stated they had not submitted a Critical Incident System (CIS) report related to the improper care of the identified resident. The ED stated there had not been any discussion that what happened to the identified resident was improper care.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director: Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm. [s. 24. (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 a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately reports the suspicion and the information upon which it is based to the Director: Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm, to be implemented voluntarily.

Issued on this 12th day of April, 2019

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

Original report signed by the inspector.

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIE LAMPMAN (522)
Inspection No. / No de l'inspection :	2019_725522_0001
Log No. / No de registre :	001979-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Mar 26, 27, 2019
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Aylmer Long Term Care Residence 465 Talbot Street West, AYLMER, ON, N5H-1K8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lori Demaiter

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

Order # / Ordre no : 001 **Order Type / Genre d’ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19(1) of LTCHA 2007.

Specifically, the licensee must ensure that:

a) Residents are not neglected by the licensee or staff;

b) Residents are reassessed as ordered, specifically an identified resident and any other residents who require specific testing. These reassessments will be documented;

c) Registered staff will receive education on specific policies of the home;

d) Documentation is kept related to the education.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Long-Term Care Homes Act, 2007 defines neglect as “The failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.”

1) A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

The complainant forwarded email correspondence they had with the Director of Care (DOC) at Chartwell Aylmer. The complainant stated in the email to the DOC that they were concerned that the identified resident had a significant change in condition and the registered staff had failed to complete an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

The DOC responded to the complainant's email and acknowledged that the registered staff had not completed an appropriate assessment of the identified resident and failed to provide appropriate interventions immediately when the significant change in condition occurred.

A review of the identified resident's hard copy chart noted the resident was admitted to the home on a specific date.

A) A review of the identified resident's New Admission/Move-in Order and Information Form dated the resident's date of admission, noted that the identified resident had a specific diagnosis that was managed by a specific medication. There was a hand written order to continue a specific dosage of the specific medication. The applicable medication sources/lists referenced were noted as "CCAC/Resident Assessment Instrument" and "Family/Resident List."

A review of the identified resident's hard copy chart noted a Community Care Access Centre (CCAC) -Resident Assessment Instrument (RAI), a hospital discharge record and a patient medication profile from the identified resident's pharmacy. The three documents noted that the resident received a lower dosage of the specified medication than that specified on the identified resident's New Admission/Move-in Order and Information Form.

In a telephone interview, a Registered Nurse (RN) stated they had completed the identified resident's admission orders using the CCAC-RAI and they had spoken with the identified resident's family. Inspector reviewed the CCAC-RAI, the hospital discharge record and the patient medication profile from the identified resident's pharmacy with the RN. Inspector inquired why the RN had indicated on the identified resident's New Admission/Move-in Order and Information Form that the identified resident was to continue to receive a higher

dosage of the specific medication than what was indicated on the documents. The RN stated they couldn't recall why there was a difference in the identified resident's admission order compared to the medication sources available on admission.

In an interview, a Registered Practical Nurse stated they completed the first check of the identified resident's admission orders. The RPN stated they would have done the check to ensure what was on the doctor's orders matched what was electronically in the computer in the identified resident's electronic Medication Administration Record (eMAR). The RPN stated they generally do not review any admission documents when completing the first or second check of a resident's admission orders. The RPN stated they would only review documents related to medication if they were initiating the admission orders.

In a telephone interview, the Physician stated they were the identified resident's attending physician and would have approved the identified resident's admission orders verbally over the phone. The Physician stated usually the registered staff would call them with the new orders for an admission. The Physician stated they would not make any changes to what a resident was already receiving, therefore they had continued the order for the higher dosage of the specific medication for the identified resident as this was what registered staff indicated that the identified resident was receiving. The Physician stated usually they do not double check the orders against the admission documents provided for a resident as the nurse would do this.

In an interview, the Director of Care reviewed the identified resident's hard copy file and compared the admission documents against the New Admission/Move-in Order and Information Form. The DOC stated they could not understand why there was a discrepancy in the identified resident's ordered medication. The DOC reviewed the resident's electronic file and noted a Ministry of Health and Long-Term Care Health Assessment dated two years earlier, which indicated the identified resident was on a higher dosage of the specific medication. The DOC stated the RN completing the identified resident's admission orders had referenced the wrong document when completing the medication reconciliation.

The DOC stated the registered staff who completed the first and second check of the identified resident's admission orders should have checked to see that the

orders were accurate to begin with. The DOC stated the registered staff should have gone through the same paper work that the registered nurse went through to create the orders and made sure everything was there and that nothing was missed.

B) Further review of the identified resident's New Admission/Move-in Order and Information Form noted the identified resident was to have specific testing completed daily and this was to be reassessed in two weeks.

A review of the identified resident's electronic and hard copy file noted the specific testing was stopped after two weeks and there was no documentation to support that the specific testing and results of the tests were ever reassessed as per the physician's orders.

A review of the identified resident's care plan noted the resident had a specific diagnosis and staff were to monitor specific symptoms related to the resident's diagnosis. The care plan also noted that specific testing should be completed as per the physician's order and specific results were to be reported to the physician.

Review of the identified resident's electronic progress notes noted on a specific date, approximately one month after the specific testing was to be reassessed, the identified resident had a significant change in condition. Registered staff failed to assess the resident appropriately considering symptoms of the identified resident's disease diagnosis and complete specific testing on the identified resident. It was not until approximately eight hours after the identified resident had the significant change in condition that the registered staff on duty at that time completed an appropriate assessment, which included a specific test and put appropriate interventions in place for the identified resident. After this, the identified resident returned to their previous level of functioning.

Review of the home's policy related to a specific disease diagnosis noted that when a resident was admitted to the home with a specific diagnosis the resident's admission orders would include the frequency of specific testing. The policy stated that the specific testing should be completed upon administration of specific medication unless otherwise ordered by the physician.

Review of the home's policy related to symptoms of a specific disease diagnosis noted when a resident displays specific symptoms, specific testing should be performed immediately.

In an interview, a Registered Nurse (RN) stated they were aware that the identified resident was on a specific medication. Upon reviewing the identified resident's electronic and hard copy file with the Inspector, the RN confirmed that registered staff stopped completing specific testing on the identified resident two weeks after the specific testing was ordered. The RN stated they would leave the reassessment of the specific testing up to the resident's physician to reorder. The RN confirmed that there was no documentation in the identified resident's electronic and hard copy chart regarding a reassessment of the identified resident's specific testing and the results of those tests.

The RN stated they were the registered staff in charge on a specific date and they had been called to assess the identified resident, as the resident had a change in condition. The RN stated they completed a set of vital signs on the identified resident but did not complete specific testing. The RN stated they should have completed specific testing on the identified resident when the resident had a change in condition, and they failed to do so.

In a telephone interview, a Registered Practical Nurse (RPN) stated they were working days in the home on a specific date. The RPN stated they were asked by another RPN to assess the identified resident, as the resident had a change in condition. The RPN told the other RPN that this was a change for the identified resident. The RPN stated at the time, specific testing was not completed on the identified resident. The RPN stated they knew that they should have completed specific testing on the identified resident, as the resident had a specific diagnosis and had a change in condition.

The RPN stated when the identified resident's specific tests were to be reassessed after two weeks, registered staff should have made a note for the physician on the doctor's board, and probably noted that the identified resident was refusing the tests. The RPN stated that registered staff probably forgot to document the reassessment in the identified resident's progress notes.

In a telephone interview, a RPN stated they provided care to the identified

resident on the specific date. The RPN stated when they saw the identified resident, they thought the identified resident was deteriorating. The RPN stated they had not seen the identified resident in a couple of days and asked another RPN to assess the identified resident. The RPN stated the RN also assessed the identified resident. The RPN stated they should have completed specific testing on the identified resident, and they did not.

In an interview, a RPN stated they provided care to the identified resident on a specific shift. The RPN stated the identified resident had a significant change in condition. The RPN stated due to the fact the identified resident had a specific diagnosis and received specific medication they decided to complete a specific test on the resident. Due to the result of the specific test the RPN provided the identified resident with appropriate interventions and the resident returned to their usual self.

The RPN stated if specific testing for the identified resident was to be reassessed after two weeks, this should have been put on the doctor's board for the physician to reassess. The RPN stated the registered staff did have a discussion and questioned why the identified resident did not have specific testing ordered.

In a telephone interview, the Physician stated they were the attending physician for the identified resident. The Physician stated if the identified resident was to have specific testing reassessed in two weeks the nurse would usually record this on the doctor's board or call the doctor. The Physician stated they did not keep the notes from the doctor's board that they were left in the home. The Physician stated that if they reassessed the specific testing for the identified resident then they would have documented this in the identified resident's progress notes. Inspector informed the Physician that there was no documentation from registered staff or the physician related to a reassessment of the specific testing for the identified resident. The Physician and Inspector reviewed the identified residents specific test results for an identified two week period. The Physician stated registered staff should have let them know that the specific testing for the identified resident needed to be reordered.

The Physician stated they recalled being called by registered staff on the specific date, about the identified resident's change in condition. Inspector

inquired why the Physician had not ordered specific testing for the identified resident. The Physician stated their instruction was always to check vitals. The Physician stated vitals would include blood pressure, heart rate, respirations, oxygen and specific testing if the resident had a specific disease diagnosis.

In an interview, the Director of Care (DOC) stated when the specific testing for the identified resident was to be reassessed after two weeks that this would generally go on the doctor's board for reassessment. The DOC stated registered staff may not necessarily document in the resident's progress notes the outcome of the reassessment but that it would be good nursing practice to document the reassessment. The DOC stated they would expect the physician to be aware that the specific testing for the identified resident needed to be reassessed and then follow up. The DOC stated they did not keep records in the home of the notes from the doctor's board.

The DOC stated they were aware of the change in condition for the identified resident. The DOC stated they would expected registered staff to have a collaborative discussion on what measures they needed to take when the identified resident had a change in condition. The DOC stated they would have expected there to be some discussion that the identified resident had a specific diagnosis and was on a specific medication and the registered staff should complete specific testing on the identified resident and get an order if they had to.

The DOC stated after they had received a complaint regarding the care provided to the identified resident, they spoke with the registered staff and determined that staff had failed to complete specific tests on the identified resident when the identified resident had a change in condition.

The DOC stated they sent an email to all registered staff regarding completing thorough assessments when a resident has a significant change in health status.

The registered staff and physician failed to provide the identified resident, with the treatment and care required, this pattern of inaction jeopardized the health of the identified resident. Registered staff failed to complete the appropriate checks for the identified resident when completing the identified resident's admission

orders, resulting in the identified resident being ordered a significantly higher dose of a specific medication. Registered staff and the Physician did not ensure specific testing for the identified resident was reassessed after two weeks as specified in the identified resident's admission order. When the identified resident had a significant change in condition on a specific date, registered staff failed to complete specific testing on the identified resident, and assess the identified resident for symptoms of their disease diagnosis. It wasn't until eight hours after a documented change in the identified resident, that specific testing was completed on the identified resident and appropriated interventions were put in place for the identified resident.

2) Another identified resident was admitted to the home on a specific dated, with a specific diagnosis, which required specific medication.

Review of the identified resident's electronic progress notes noted on a specific date the physician ordered one of the medications for the specific disease diagnosis to be put on hold, specific testing was to be completed and the physician was to be notified if the test results were within a specific range. These orders were to be reassessed in two weeks.

On two occasions, the identified resident's test results were within a specific range. There was no documentation in the identified resident's progress notes to support that the physician was notified, as per the physician's orders. No further testing was documented after the two week period. There was no documented reassessment of the specific testing for the identified resident and the resident's medication remained on hold.

Further review of the identified resident's progress notes noted that approximately one month after the specific testing was stopped and the medication was put on hold, the family requested the identified resident to have the specific testing completed as they felt the identified resident was not themselves. The specific testing noted that the results for the identified resident were higher than normal, after the specific testing was completed several times, the identified resident was ordered new medication and the specific testing was reordered.

In an interview, a Registered Nurse (RN) stated if the specific testing was only

for two weeks then they would leave the follow-up with the physician. The RN stated they would make a note for the doctor that the specific testing needed to be reassessed.

In an interview, a Registered Practical Nurse stated they would make a note for the doctor if specific testing for a resident needed to be reassessed.

In a telephone interview, the Physician stated they rely on the registered staff to let them know if a resident needs to be reassessed and orders continued. The Physician stated if this happened then it would be documented in the resident's progress notes.

In an interview, the Director of Care stated that they would expect to see that it was documented in the identified resident's progress notes that staff called the doctor when the specific testing for the identified resident noted the results fell within a specific range, as per the doctor's orders. The DOC stated they thought the order for the specific testing would automatically come off the eMAR after the two weeks if there was no reassessment or changes to the order. The DOC stated they would expect both the doctor and the registered staff to follow up regarding the specific testing for the identified resident after the identified resident's medication was put on hold.

The registered staff and physician failed to provide the identified resident with the treatment and care required, this pattern of inaction jeopardized the health of the identified resident. The Physician put the identified resident's specific medication on hold and ordered specific testing two days per week for two weeks with a request to be notified if the identified resident's test results were within a specific range. On two occasions the identified resident had documented test results that were within the specific range and the physician was not notified. After the two week period registered staff stopped the specific tests on the identified resident and the resident's medication remained on hold. There was no documentation by registered staff or the physician to indicate that the identified resident had been reassessed and there had been a discussion regarding the identified resident's test results and discontinuation of the specific tests and medication for the identified resident. It was not until the identified resident's family requested that staff complete a specific test on the identified resident, that it was determined that the results for the specific test were higher

than normal. The identified resident was then put on a specific medication and specific testing was reordered.

The licensee has failed to ensure that residents were not neglected by the licensee or staff. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it was a pattern, involving two out of three residents. The home had a level 2 history of unrelated noncompliance. (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with r. 8. (1)(b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that:

a) Classic Care Pharmacy's "Medication Reconciliation - Long Term Care Homes" policy is complied with;

b) The home's "Medication Reconciliation" policy is complied with;

c) All registered staff and the home's physicians receive education on Classic Care Pharmacy's "Medication Reconciliation - Long Term Care Homes" policy, and the home's "Medication Reconciliation" policy;

d) Documentation is kept related to the education.

Grounds / Motifs :

1. The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

Ontario Regulation 79/10, r. 114 (2) states, "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."

A complaint was received by the Ministry of Health and Long-Term Care related to negligent care towards an identified resident by the staff at Chartwell Aylmer.

A review of the identified resident's hard copy chart noted the resident was admitted to the home on a specific date, with an admission order of a specific dose of a medication.

In an interview, the Director of Care (DOC) stated that the home's Medication Reconciliation policy was a general policy and the Classic Care Pharmacy policy Medication Reconciliation – Long-Term Care Homes, would be the overarching policy that staff would follow.

Review of Classic Care Pharmacy's policy "Medication Reconciliation - Long Term Care Homes" 2.7.1, with a review date of December 2016, noted the following:
"New admission to the Long Term Care Home procedure:
"The nurse creates the Best Possible Medication History (BPMH) from all possible sources, including, but not necessarily limited to:
a. MAR (LTCH/RH, Hospital)
b. CCAC/ Resident Assessment Instrument
c. Discharge List/Prescriptions from hospital
d. Community Pharmacy Medication List
e. Medication Vials/Package
f. Family/Resident list
g. Other"

"The nurse documents all relevant sources used to create the BPMH from the list provided in the upper right hand corner of the form. During this process, it is crucial to compare the orders, monitoring for any discrepencies. If a discrepency is discovered, document the details in the comments section next to the medication order. Resolve any identified discrepencies with the most appropriate health care professional."

"In the usual manner, the nurse contacts the resident's attending physician."

“The physician assesses the nurse prepared medication profile on the Triplicate Medication Reconciliation and Admission Order Form(s) (and any supporting documents as applicable) and provides direction to continue, discontinue or hold each listed medication and documents by checking the appropriate box for each order...Once authorized by the physician, the resultant list becomes the Resident's admission orders and further orders are not permitted to be added to the page(s).”

“The medication orders are first and second checked by two different nurses according to usual routine. Available source documents are reviewed as applicable.”

Review of the home's policy "Medication Reconciliation" LTC-CA-WQ-200-06-12, with a review date of December 2017, noted the following:

“On admission Registered Staff will obtain from the resident and family a best possible medication history (BPMH). This history will be reviewed by the physician/nurse practitioner as a component of the admission process and approving the medication regime for the new resident.”

A review of the identified resident’s New Admission/Move-in Order and Information Form dated the resident’s date of admission, noted that the identified resident had a specific diagnosis that was managed by a specific medication. There was a hand written order to continue a specific dosage of the specific medication. The applicable medication sources/lists referenced were noted as “CCAC/Resident Assessment Instrument” and “Family/Resident List."

The New Admission/Move-in Order and Information Form was signed as a phone order by a Registered Nurse (RN) for the Physician on the identified resident’s admission date. "Checking Nurse 1" and "Checking Nurse 2" both signed the form on the identified resident’s admission date.

A review of the identified resident’s hard copy chart noted a Community Care Access Centre (CCAC) -Resident Assessment Instrument (RAI), a hospital discharge record and a patient medication profile from the identified resident’s pharmacy. The three documents noted that the resident received a lower dosage

of the specified medication than that specified on the identified resident's New Admission/Move-in Order and Information Form.

In a telephone interview, a Registered Nurse (RN) stated they had completed the identified resident's admission orders using the CCAC-RAI and they had spoken with the identified resident's family. Inspector reviewed the CCAC-RAI, the hospital discharge record and the patient medication profile from the identified resident's pharmacy with the RN. Inspector inquired why the RN had indicated on the identified resident's New Admission/Move-in Order and Information Form that the identified resident was to continue to receive a significantly higher dosage of the specific medication than what was indicated on the documents. The RN stated they couldn't recall why there was a difference in the identified resident's admission order compared to the medication sources available on admission.

The RN stated that the registered staff on evenings would have completed the additional checks of the orders for the identified resident. The RN stated that when registered staff complete the first and second check of the admission orders they do not compare the orders on the New Admission/Move-in Order and Information Form against the medication source documents.

In an interview, a Registered Practical Nurse stated they completed the first check of the identified resident's admission orders. The RPN stated they would have done the check to ensure what was on the doctor's orders matched what was electronically in the computer in the identified resident's electronic Medication Administration Record (eMAR). The RPN stated they generally do not review any admission documents when completing the first or second check of a resident's admission orders. The RPN stated they would only review documents related to medication if they were initiating the admission orders.

In a telephone interview, the Physician stated they were the identified resident's attending physician and would have approved the identified resident's admission orders verbally over the phone. The Physician stated usually the registered staff would call them with the new orders for an admission. The Physician stated they would not make any changes to what a resident was already receiving, therefore they had continued the order for the higher dosage of the specific medication for the identified resident as this was what registered staff indicated that the

identified resident was receiving. The Physician stated usually they do not double check the orders against the admission documents provided for a resident as the nurse would do this.

In an interview, the Director of Care reviewed the identified resident's hard copy file and compared the admission documents against the New Admission/Move-in Order and Information Form. The DOC stated they could not understand why there was a discrepancy in the identified resident's ordered medication. The DOC reviewed the resident's electronic file and noted a Ministry of Health and Long-Term Care Health Assessment dated two years earlier, which indicated the identified resident was on a higher dosage of the specific medication. The DOC stated the RN completing the identified resident's admission orders had referenced the wrong document when completing the medication reconciliation.

The DOC stated the registered staff who completed the first and second check of the identified resident's admission orders should have checked to see that the orders were accurate to begin with. The DOC stated the registered staff should have gone through the same paper work that the registered nurse went through to create the orders and made sure everything was there and that nothing was missed.

The licensee has failed to ensure where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 3 as it was widespread. The home had a level 3 history of noncompliance with this section of Ontario Regulation 79/10, which included a Voluntary Plan of Correction on November 7, 2017 (2017_563670_0023). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019

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 Health and 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:

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 Health and 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.

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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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 de la Santé et 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 26th day of March, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Julie Lampman

Service Area Office / Bureau régional de services : London Service Area Office