Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Sep 27, 2019	2019_791739_0028	015979-19	Complaint

Licensee/Titulaire de permis

Meritas Care Corporation
567 Victoria Avenue WINDSOR ON N9A 4N1

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

Chateau Park Long Term Care Home
2990 B Riverside Drive West WINDSOR ON N9C 1A2

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

JULIE DALESSANDRO (739)

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): September 23, 24, and 26, 2019.

The following Complaint Log was inspected:

Log #015979-19 related to maintenance, nutrition, medication, and responding to complaints.

**During the course of the inspection, the inspector(s) spoke with The home's Maintenance Staff Member, Personal Support Worker(s), Registered Practical Nurse (s),
Registered Nurse(s), the home's Dietitian, The Director of Nursing, and the home's Administrator.**

During the course of this inspection the inspector(s) also completed record reviews and observations relevant to the inspection.

**The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Medication
Nutrition and Hydration
Reporting and Complaints**

During the course of this inspection, Non-Compliances were issued.

- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 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 requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee is required to ensure that the policy is complied with. O. Reg. 79/10, s. 8 (1).

The Long-Term Care Homes Act states that (1) Every licensee of a long-term care home, (a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and (b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

The Long-Term Care Home Act also states that if a resident is being restrained by the administration of a drug, the licensee shall ensure that the drug is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36. (4).

A complaint letter was sent to The Ministry of Long-Term Care on a specific date. The complainant stated that they had concerns regarding medication administration practices, specifically drugs used to restrain residents, at the home for resident #001.

A record review of the home's Policy titled Minimizing Restraints Program, last revised May 2015 and last reviewed May 2018, stated that chemical restraints are pharmaceuticals that were given with the specific and sole purpose of inhibiting specific behavior. The policy also stated that if a resident was restrained by the administration of a drug when immediate action was necessary to prevent serious bodily harm or to others the following must have been documented:
1. Circumstances precipitating the administration of the drug
2. Who made the order?

3. What drug was administered?
4. The dosage given
5. By what means the drug was administered
6. Who administered the drug?
7. The resident's response to the drug

The home's policy also stated that the documentation requirements, if restrained by a drug, included a discussion with the resident/Substitute Decision Maker (SDM) following the administration of the drug to explain the reasons for the use of the drug.

Record review of resident #001's Medication Administration Record (MAR) for a specific month showed that resident #001 had an order for a drug which restrained behaviour. During the month, resident #001 received this medication on five separate occasions.

During an interview with Director of Nursing (DOC) #100, Registered Nurse (RN) #101, RN #102, and Registered Practical Nurse (RPN) #103, they stated that they considered the medication to be a chemical restraint. RN #101 stated that they would give the medication when resident #001 had behaviours that were out of control and RN #102 stated that they would give the medication when staff were unable to re-direct resident #001 due to agitation.

A record review of resident #001's progress notes in Point Click Care (PCC) from a specific time period revealed that the home did not document that a discussion with resident #001's SDM was had, following the administration of the medication to explain the reasons for the use of the drug, on two separate dates.

A record review of resident #001's progress notes in PCC from a specific time frame also revealed that home did not document the circumstances precipitating the administration of the drug or the resident's response to the drug on one of those dates.

DOC #100 stated that there was no documentation to support any discussion with the POA in the resident's chart after the medication was given on two separate dates and that there was no documentation regarding the circumstances precipitating the administration of the drug or the resident's response to the drug on one of those dates. DOC #100 acknowledged that the home did not follow their policy for minimizing restraints for resident #001. [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 the restraint policy of the home is complied with., to be implemented voluntarily.

WN #2: 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 :

1. The licensee has failed to ensure that 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).

A complaint letter was sent to The Ministry of Long-Term Care on a specific date. The complainant stated that they had concerns regarding the home's timeline for responding to their complaint regarding the care of resident #001. The complainant also stated that they were not confident that the complaint was forwarded to the Ministry of Long-Term Care as requested by the complainant and as required by the Long-Term Care Homes Act.

During an interview with Administrator #106, they stated that for a period of time in 2018 the home was getting viruses to their e-mail and several e-mails were placed into a junk mail folder. They then stated that is wasn't until the complainant sent a follow-up e-mail on a certain date that they were able to locate the original e-mail in their junk folder. Administrator #106 stated that they responded to the e-mail concern one day later.

Record review of the e-mail thread between the complainant and Administrator #106 revealed that although a response was sent to the complainant, the complaint was not forwarded to the Ministry of Long-Term Care until thirteen days after the complaint was received.

Record review of the home's policy titled, 'Concern/Complaint– How to Handle', last revised October 2017 and last reviewed October 2018 stated that, the Administrator (and/or delegate) should have forwarded all written complaints received by the home immediately to the Ministry of Health.

Administrator #106 acknowledged that the home failed to immediately report the complaint regarding the care of resident #001 to the Ministry of Long-Term Care as stated in the Act. [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 each written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director., to be implemented voluntarily.

Issued on this 27th day of September, 2019

[redacted]

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

Original report signed by the inspector.