Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 8, 2017	2017_370649_0017	023332-17	Resident Quality Inspection

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 Gibson Long Term Care Residence
1925 STEELES AVENUE EAST NORTH YORK ON M2H 2H3

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

JULIEANN HING (649), MATTHEW CHIU (565)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 5, 6, 10, 11, 12, 13, and 16, 2017.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Services (DRS), Environment Manager (EM), Resident Assessment Instrument (RAI) Co-ordinator, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeping Aide (HA), Substitute Decision Makers (SDMs), and residents.

The inspectors conducted a tour of the resident home areas, observation of medication administration, staff and resident interactions, provision of care, record review of resident and home records, reviewed meeting minutes of Residents' Council, staffing schedules, relevant policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

During the Resident Quality Inspection (RQI) a review of the home's medication incident reports for the last quarter was conducted. Resident #010 was identified as having a medication error. Review of the medication incident report on an identified date in July 2017, revealed that resident #010 had been ordered an identified medication to be administered twice daily in April 2017, and the order had been discontinued by the doctor in June 2017, because the resident had been refusing this medication. According to the medication incident report the medication was still being sent by the pharmacy with the residents' weekly medication supply.

A review of the home's policy titled 06-Pharmacy and Therapeutics, revision dates of November 2014, July 2015, April 2017, revealed the registered staff will "double check the eMAR screen to ensure all medications ordered at that med pass are given or accounted for".

Interview with RPN #118 revealed that that he/she had worked on identified dates in June and July 2017, with resident #010 and had not checked to ensure the medications in the packaging matched the medications in the eMAR. The RPN stated that the medications in the packaging should match the eMAR and confirmed that resident #010 had received the identified medication that had been discontinued.

Interview with the Director of Resident Services (DRS) revealed that the home's medication policy had not been followed as the staff should had picked up on the mistake when the medication continued to sent by the pharmacy after it had been discontinued. [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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

During the RQI a review of the home's medication incident reports for the last quarter was conducted. Resident #010 was identified as having a medication error. Review of the medication incident report on an identified date in July 2017, revealed that resident #010 had been ordered an identified medication to be administered twice daily in April 2017, and the order had been discontinued by the doctor in June 2017, since the resident had been refusing this medication. According to the medication incident report the identified medication was still being sent by the pharmacy with the resident's weekly medication supply.

A review of the home's weekly supply of medication from the pharmacy for the period of June to July 2017, revealed that each week the identified medication were sent to the home for administration to resident #010.

Interview with RPN #118 revealed that that he/she had worked in June and July 2017, with resident #010 and remember putting the discontinued sticker on the remaining week medication supply when the drug had been discontinued in June 2017. The RPN could not recall if he/she had continued to put the discontinued sticker on the the following weeks supply of this medication from the pharmacy. The RPN told the inspector that he/she had administered the discontinued medication to resident #010 at the 0800 hours medication pass when he/she had worked.

Interview with the DRS revealed that the registered staff had not followed the physician's order and the mistake with the medication should have been immediately picked up when it first showed up in the strip packaging from pharmacy. [s. 131. (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 no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

Issued on this 14th day of November, 2017

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

Original report signed by the inspector.