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
Aug 20, 2018	2018_462600_0011	015599-18	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

GORDANA KRSTEVSKA (600), NITAL SHETH (500), REBECCA LEUNG (726), STELLA NG (507a)

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): July 4, 5, 6, 9, 10, 11, 12, and 13, 2018.

During this inspection Critical Incident (CI) #2556-000020-18, intake #017566-18, was inspected regarding abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Residents' Council president, Personal Support Workers (PSWs), Dietary Aide (DA), Occupational Therapist (OT), Substitute Decision Makers (SDM) and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Critical Incident Response
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident.

Resident #009 was triggered for potential restraints in stage one of the Resident Quality Inspection (RQI).

A review of the Occupational Therapist's (OT) admission note on an identified date indicated that resident #009 required an identified device as a personal assistance services device (PASD). OT indicated the position of the device should be changed regularly every one to two hours and an identified part of the device should be monitored each time that they were being transferred in the device. Nursing staff should monitor resident #009 in the device for safety as resident #009 was in a new environment and inform OT or Physiotherapist (PT) if there was any issue with the position of the device.

A review of resident #009’s written plan of care kardex did not reveal any focus, goal or intervention developed related to using assisting device as PASD and the required care, repositioning and monitoring as recommended by the OT in the OT note on an identified date.

Review of the task assignment for Personal Support Worker (PSW) in Point of Care (POC) indicated the task: PASD: assisting device, change position every two hours while up in device during two scheduled times during the day shift and as needed (PRN). Review of task recorded in POC history from an identified period of time indicated that the above scheduled task was performed twice during day shift only. No record of the above scheduled task was being performed during the evening shift.

In an interview, PSW #105 stated that they had been repositioning resident #009 every two hours when resident #009 was up in the device during the day shift. PSW #105 confirmed that they were aware of the direction for repositioning only, but not any other directions from the OT.

In an interview, PSW #106 stated that resident #009 was usually up in the device at around a specified hours until after dinner, and they repositioned resident #009 every two hours when resident #009 was in the device. However, when the inspector requested PSW #106 to show the documentation in POC to support that they had been

repositioning resident #009 every two hours when resident #009 was up in the device, PSW #116 was unable to find the task assigned in POC for repositioning resident #009 every two hours in the evening shift. Registered Nurse (RN) #117 reviewed resident #009's file in POC and confirmed that the task for repositioning every two hours had been assigned for one shift only, and there was no record in POC for repositioning every two hours during the evening shifts.

In an interview, RN #112 confirmed that there was no information written in resident #009's written plan of care to provide directions to the PSW regarding the specific care and monitoring for resident #009 when they were being placed in a changed position in the device. After reviewing OT's admission note dated November 29, 2017, during the interview, RN #112 further confirmed that OT's recommendations regarding the use of tilt wheelchair as PASD and the required monitoring and repositioning had not been transcribed to resident #009's written plan of care to offer clear directions to staff who provide direct care to resident #009. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee had failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

During the RQI, a review of the home's medication incident reports for the previous quarters and home's process for handling of medication incidents and adverse drug reactions was conducted.

Review of the medication incident report on an identified date, involving resident #012 indicated that resident #012 was prescribed by the physician to have two identified medications by mouth once daily at noon, but resident #012 did not receive both medications at noon as prescribed. As the registered nursing staff on day shift signed in the Electronic Medication Administration Record (eMAR) that these two medications were given to resident #012 at noon, the incident was not discovered until afternoon hours when the registered nursing staff on the following shift found the medication pouch from an identified date and time with the identified medication. The registered nursing staff on the following shift then notified the physician and received an order from the physician to give both medications until later in the day once resident #012 returned to the home. No adverse reaction was indicated in the medication incident report.

Review of the medication incident report on an identified date, involving resident #030 indicated that the physician wrote a new medication order on an identified date, to change the frequency of one of the medications. The registered nursing staff found the order unclear, but did not verify the order with the prescribing physician on the same day. The new medication order was not processed. The medication incident was reported on a specified date. Resident #030 missed one dose on both dates. No adverse reaction was indicated in the medication incident report.

In an interview with the Director of Care (DOC), the inspector reviewed with the DOC the two medication incidents involving resident #012 and resident #030, DOC confirmed that the registered nursing staff did not administer the medication to the resident in accordance with the directions for use specified by the physician. [s. 131. (2)]

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 drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute

decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

During the Resident Quality Inspection (RQI), a review of the home's medication incident reports for the previous quarters and home's process for handling of medication incidents and adverse drug reactions indicated that in three of the reviewed medication incidents the home did not report the incidents to the three residents involved and their SDM, and also the Medical Director.

Review of the medication incident report on an identified date, involving resident #001 indicated the pharmacy continued to send strips with two tablets of an identified medication four times daily despite the physician having changed the order on an identified date. The medication incident was reported on a specified date. A review of the medication incident report states staff had been giving medication as per the physician's order. No documentation was found in the medication incident report package or home's electronic health record system, Point Click Care (PCC), that resident #001 and resident #001's SDM had been informed regarding this medication incident.

Review of the medication incident report dated on an identified date, involving resident #012 indicated that resident #012 was prescribed by the physician to have identified medications as ordered but resident #012 did not receive both medications at the identified time as prescribed. As the registered nursing staff on day shift signed in the Electronic Medication Administration Record (eMAR) that these two medications had been given to resident #012 at an identified time, the incident was not discovered until hours later when the registered nursing staff on evening shift found the medication pouch on an identified date with identified medications. The registered nursing staff on evening shift then notified the physician and received an order from the physician to give both medications until later in the day once resident #012 returned to the home. No adverse reaction was indicated in the medication incident report. No documentation was found in the medication incident report package or home's electronic health record system, that resident #012 and resident #012's SDM had been informed regarding this medication incident.

Review of the medication incident report on an identified date, involving resident #030 indicated that the physician wrote a new medication order on an identified date, to change a frequency to one of the medication. The registered nursing staff found the order unclear, but did not verify the order with the prescribing physician on the same day. The

new medication order was not processed. The medication incident was reported on an identified date. Resident #030 missed one dose on each dates. No adverse reaction was indicated in the medication incident report. No documentation was found in the medication incident report package or PCC that resident #030 and resident #030's SDM had been informed regarding this medication incident.

In an interview with the Director of Care (DOC), DOC confirmed that there was no documentation to support that resident #001, #012 and resident #030, and their SDMs had been informed regarding the medication incidents that the residents were involved. The DOC also confirmed that the medical director had not been informed regarding these two medication incidents during the Professional Advisory Committee meetings as the meeting minutes did not record any discussion about these two medication incidents.

The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), and the Medical Director. [s. 135. (1)]

2. The licensee had failed to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything provided for in clauses (a) and (b).

During the Resident Quality Inspection (RQI), a review of the home's medication incident reports for the previous quarters and home's process for handling of medication incidents and adverse drug reactions was conducted. It was found that a quarterly review was not completed for medication incidents that occurred in the first quarter of 2018 and the fourth quarter of 2017.

Review of the medication incident binder provided by the DOC indicated that there was one medication incident reported in the previous quarter of January-March 2018 (Q1), and more than two medication incidents were reported in the previous quarter of October-December, 2017 (Q4).

In an interview the DOC confirmed that the home had not completed the quarterly review for the medication incidents occurred in the previous quarters of January-March 2018 (Q1) and October-December, 2017 (Q4). [s. 135. (3)]

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 every medication incident involving a resident and every adverse drug reaction was reported to the resident, the resident's substitute decision-maker (SDM), if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider,
- to ensure that:
(a) a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;
(b) any changes and improvements identified in the review were implemented; and
(c) a written record was kept of everything provided for in clauses (a) and (b), to be implemented voluntarily.

Issued on this 27th day of August, 2018

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

Original report signed by the inspector.