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 # / Registre no	Type of Inspection / Genre d'inspection
Aug 17, 2016	2016_286547_0020	013527-16	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

RESIDENCE CHAMPLAIN
428 Front Road West L'Orignal ON K0B 1K0

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

LISA KLUKE (547), MELANIE SARRAZIN (592)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 9,10,11,12,15 and 16, 2016

During the course of this Resident Quality Inspection, Inspectors also conducted two concurrent Critical incidents reported by the home.
Log #017372-16 related to resident to resident alleged abuse and Log #013766-16 related to staff to resident alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), RAI/MDS Coordinator, a Program Manager, Registered Dietitian (RD), a Pharmacist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Behaviour Support Ontario Staff, a Housekeeping Aide, President of Resident and Family Councils, Residents and Family Members.

In addition the inspection team conducted a tour of the resident care areas, reviewed resident health care records, resident council minutes, reviewed the home's policies and procedures, staff work routines, documents related to the home's investigations into alleged incidents of abuse/neglect. The inspection team observed aspects of resident care and interactions with staff.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

1 WN(s)
0 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 the home's Medication Administration and Disposal of Medications policies and procedures in place during this inspection were complied with.

In accordance with O.Reg.79/10, s.114(2) 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.

The home's "Medication Administration" policy # LTC-CA-WQ-200-06-01 last revised July 2015 stated the following regarding the procedure after administering a medication to a resident:

"8.k-return to medication cart and sign for the administration of each medication given before proceeding to the next resident. It is further indicated that where medications are refused or held, use appropriate numbered code on Medication Administration Record (MAR)sheet and chart in the progress notes".

The home uses an electronic MAR to verify and document medication administration to residents.

During an observation of the East medication cart on August 11, 2016, Inspector #592 observed in the presence of RPN #105 inside the top drawer of the medication cart, three

open medication pouches containing medications. RPN #105 indicated that one of these pouches belonged to resident #041 that contained a specified medication. Upon review of resident #041's MAR, RPN #105 indicated that this medication was to be provided to resident #041 on previous day at a specified time. RPN #105 further noted that this medication was checked-off, which indicated as per the home's chart coding, as medication administered. RPN #105 indicated that the medication was not administered as it remained in the pouch inside the medication cart drawer.

In an interview with the home's pharmacist, he told Inspector #592 that registered nursing staff members are to document after each medication is administered to a resident using the chart codes located in the MAR.

In an interview with the Administrator, she was made aware of the Inspector's observation and confirmed that medications are to be recorded on the MAR using the appropriate numbered codes only once they have been administered to a resident. The Administrator indicated in a later interview this same date, that the RPN confirmed with the Administrator that she had checked off this specified medication in the MAR without administering it to resident #041 as she had placed the medication and pouch aside to verify the physician orders and forgot about it later, and never returned to the medication cart to administer this medication to resident #041.

In accordance with O.Reg.79/10, s.136(2)1. the licensee shall ensure that the drug destruction and disposal policy must provide that drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs.

The home's "Disposal of Discontinued Medications" policy # 02-06-20 last revised June 23, 2014 stated the following in tab.2:

"Drugs that are to be destroyed and disposed of, are to be stored safely and securely. The policy further indicated that each nursing station will have a clearly marked storage area for discontinued or outdated medications that is separate from drugs that are available for administration to residents".

During this same observation of the East medication cart on August 11, 2016, Inspector #592 and RPN #105 also observed two other open medication pouches containing medications inside the top drawer of the medication cart, that were not identified with any resident name as they have been torn open and resident's names were destroyed.

Inspector #592 and RPN #105 observed that one medication pouch contained two specified medication tablets and the second medication pouch contained one specified medication tablet. RPN #105 indicated that these medication dosages were changed or discontinued and therefore removed from the resident individual bins for later destruction. RPN #105 further indicated to Inspector #592 that the home's expectation is that all discontinued medications should have been removed from the medication cart and discarded in a white pail which is sealed with a lid and located in the medication room.

RN #106 confirmed with Inspector #592 and the home's pharmacist that all non-controlled medications that are discontinued or expired should be discarded in the white pail located in the locked medication room. The pharmacist further indicated that the discontinued/expired medications should not be kept with the active medications in the medication cart to avoid medication errors. [s. 8. (1) (b)]

Issued on this 17th day of August, 2016

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

Original report signed by the inspector.