Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 26, 2020	2020_594746_0006	000578-20	Complaint

Licensee/Titulaire de permis

Trilogy LTC Inc.
7070 Derrycrest Drive MISSISSAUGA ON L5W 0G5

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

Chartwell Trilogy Long Term Care Residence
340 McCowan Road SCARBOROUGH ON M1J 3P4

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

AMANDEEP BHELA (746)

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 9, 10, 11, 12, 13 and 16, 2020.

One log related to medication administration.

During the course of the inspection, the inspector(s) spoke with Director of Care (DOC), Associate Director of Care (ADOC), Facility Charge Nurses (FCNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and Substitute Decision Maker (SDM).

During the inspection, the inspector reviewed resident health records and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Medication

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

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Findings/Faits saillants :

1.The licensee has failed to ensure that resident #002's Substitute Decision Maker (SDM) was given an opportunity to participate fully in the development and implementation of the resident's plan of care.

The Ministry of Long-Term Care (MLTC) received a complaint, related to the home administering a medication to resident #002, without consent from the SDM.

An interview with the complainant indicated, they were informed by the day nurse at the home that resident #002 was being rushed to hospital for medical assessment. The complainant indicated later that evening, resident #002 was discharged from hospital and returning to the home with the SDM, the SDM indicated they called the home to inform them that they will be returning to the home, the resident was stable and tests were conducted at the hospital however the hospital was unable to determine the cause of the incident in the morning. The complainant further indicated that, the nurse then informed the complainant that the home had received a drug interaction report from the pharmacy indicating that there was risk for an adverse reaction between the medication the resident had received and resident's regular scheduled medications, therefore the physician would be prescribing a different medication. The complainant indicated that the home did not receive her consent to administer this medication.

Review of the home's policy #9.3, with the tittle "Ordering New Prescriptions Using Point Click Care" listed POA notification, under Nurse Responsibilities when new orders are prescribed.

A review of resident #002's records was carried out. On an identified date RPN #100 documented an assessment of the resident's condition. Resident was assessed by the doctor and a, new medication was ordered, POA was informed via voice message. Record review further revealed that evening, RPN #104, administered the medication. Review of resident's records for an identified period, did not indicate that consent was received from resident #002's SDM.

In an interview with RPN #100, they indicated that on an identified date, resident #002 was experiencing a change in condition. The physician had assessed the resident and ordered a test and a new medication. RPN#100 indicated that they had called the SDM, however was unable to get a hold of the SDM so they left a message on their voicemail. RPN #100 further indicated that they had documented this attempt in the documentation system so that the evening staff could then follow up to receive consent from the SDM.

In an interview with RPN #104, they indicated that later that evening on the identified date, they administered the new medication without receiving consent from resident #002's SDM.

In an interview, Associate Director of Care (ADOC) #109 acknowledged that the home failed to receive resident #002's SDMs consent prior to the administration of the medication. [s. 6. (5)]

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 the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care,, to be implemented voluntarily.

Issued on this 1st day of June, 2020

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

Original report signed by the inspector.