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 3, 2019	2019_538144_0035	015421-19	Complaint

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 Royal Oak Long Term Care Residence
1750 Division Road North KINGSVILLE ON N9Y 4G7

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

CAROLEE MILLINER (144)

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): August 29, 2019.

The following intake was inspected within this inspection:
Log 015421-19, IL-69108-LO related to the plan of care and prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with one resident, one family member, one Assistant Director of Care, the Environmental Services Manager, two Registered Practical Nurses, one Personal Support Worker and one Housekeeping Aide.

During the course of the inspection, the inspector observed one resident and reviewed one resident clinical record, one medication incident report and the home's medication administration and medication incidents and adverse drug reactions policies.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Medication

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care for one resident was provided to the resident as specified in the plan.

One complaint intake included a concern related to administration of a specific medication to one identified resident that the resident was unable to take.

Review of the Point Click Care (PCC) clinical record for the resident confirmed that the resident should not have been administered the medication.

The clinical record for the resident further revealed that a physician's order was received and processed on one specified date for the medication.

The residents' medication administration record (MAR) confirmed that the medication was administered to the resident twice on one specified date.

After the identified medication was administered twice, a second physician's telephone order was received and processed to discontinue the medication

One RPN advised the inspector that the medication was administered to the resident as documented on the residents' MAR.

Assistant Director of Care (ADOC) told the inspector that the residents' Power of Attorney (POA) reported the medication incident to them.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. [s. 6. (7)]

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 care set out in the plan of care for was provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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).

Findings/Faits saillants :

1. The licensee has failed to 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.

Review of the Point Click Care (PCC) clinical record for one resident revealed that the resident could not be administered one identified medication and that the medication was administered to the resident twice on one specified date.

On the date of inspection, a medication incident report related to the medication error was not available for the inspector's review.

The ADOC told the inspector that the residents' POA reported the medication incident to them and that the POA said the error had been corrected.

The ADOC also told the inspector that when the POA advised them of the medication incident, they (ADOC) documented the incident on the home's complaint log and did not complete a medication incident report.

The home's complaint log related to the medication incident was reviewed by the inspector.

Documentation on the home's complaint log related to the medication incident did not include information required on the medication incident report such as: the origin of the incident, resident outcome, causes, contributing factors, analysis of the incident and a corrective action plan.

The ADOC advised the inspector that the home's Medication Incidents Policy included that a medication incident report would be completed for all medication incidents.

A completed medication incident report related to the medication error was completed by the ADOC on the date of this inspection and was faxed to the inspector the day after the inspection.

The licensee failed to ensure that a medication incident involving a resident was documented together with a record of immediate actions taken to assess and maintain the residents' health. [s. 135. (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 every medication incident involving a resident and every adverse drug reaction is:
documented, together with a record of the immediate actions taken to assess and maintain the resident's health, to be implemented voluntarily.

Issued on this 4th day of September, 2019

[redacted]

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

Original report signed by the inspector.