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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 3, 2016	2016_508137_0022	027449-16	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

Chartwell Elmira Long Term Care Residence
11 Herbert Street Elmira ON N3B 2B8

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

MARIAN MACDONALD (137), JANETM EVANS (659), NUZHAT UDDIN (532)

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): September 21-23 and 26-28, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, Support Services and Programs Manager, Environmental Services Manager, Physician, three Registered Nurses (RN), one Registered Practical Nurse (RPN), three Personal Support Workers (PSW), one Physiotherapy Assistant, 20 residents and four family members.

The Inspectors also toured all resident home areas, common areas, medication storage area, observed care provision, resident/staff interactions, recreational programs, medication administration, reviewed residents' clinical records, relevant policies and procedures and various meeting minutes.

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
Pain
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)**
- **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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home were kept in good repair.

Record review and bed rail assessment stated that resident # 004 used half left and right bed rails.

On September 27, 2016, an observation revealed that when moved, the left bed rail was loose, which created a gap between the mattress and the half bed rail.

On September 27, 2016, the Environmental Services Manager # 112 (ESM) observed the bed rail, with Inspector # 532, and confirmed that the bed rail was loose. The ESM said that the home relied on the nursing staff and/or the housekeeping staff to notify the environmental department, if bed rails were loose. The ESM # 112 said that if it was not reported, then the environmental department would not be aware.

A review of the policy, Resident Safety and Risk Management, Bed System Assessment # LTC-CA-ON-200-07-22, revised January 2016, indicated "that any staff noticing a mechanical issue with a bed side rail was to notify the Registered staff immediately and describe what was observed. Registered staff will inspect the bed side rail and, if required, lock it out of use until it is fixed by maintenance staff".

Inspector # 532 inquired if environmental staff completed an audit of the bed rails, to ensure that all equipment was kept in good repair.
The ESM # 112 said the process remained that nursing and housekeeping staff were to notify maintenance staff by writing it in the book.
The ESM # 112 acknowledged that the bed rail was loose and this was a problem, as it could create a space between the rail and the mattress, posing a potential risk for entrapment.
ESM # 112 further stated that the plan was to audit bed rails to ensure that assistive aids and positioning aids in the home were kept in good repair.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level two - minimal harm or for actual harm and there was no previously related non-compliance. [s. 90. (2) (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 procedures are developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

On September 27, 2016, during an observation of the first floor medication room, a locked black bin was observed in the medication room refrigerator.
Registered Nurse # 111 (RN) unlocked the bin for Inspector # 532 and four vials of Ativan Intramuscular (IM) injectable were observed in the black bin.
RN # 111 indicated that the injectable Ativan was normally stored in the locked black bin. It was noted that the black bin was transportable and not stationary.

The Director of Care # 108 (DOC) confirmed that the controlled substances were not stored in a double-locked stationary cupboard and should be.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level two - minimal harm or for actual harm and there was no previously related non-compliance. [s. 129. (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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #3: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

During an interview, with an identified resident, it was revealed that the resident self-administered medication.
During a clinical record review, it was noted that there was a physicians' order for the medication but self-administration of the drug was not approved by the prescriber.

The DOC # 108 acknowledged that there was no physician order for an identified resident to self-administer the medication and there should be a written order from the physician. [s. 131. (5)]

2. A review of plan of care and Point of Care (POC) documentation indicated that an analgesic medication was to be applied to an identified resident.
Also, there was no physician's order for the application of the analgesic medication.

On September 27, 2016, in an interview the Resident Assessment Instrument/ Minimum Data Systems (RAI/MDS) Coordinator # 102 clarified that the application of the analgesic medication was seen as a nursing measure and staff were to apply it to residents.

The scope of this area of non-compliance was determined to be a level one - isolated, the severity was a level one - minimum risk or for actual harm and there was previously related non-compliance. [s. 131. (5)]

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

Issued on this 14th day of October, 2016

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

Original report signed by the inspector.