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 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

Central West Service Area Office
500 Weber Street North
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Telephone: (888) 432-7901
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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
Dec 27, 2018	2018_727695_0017	021687-17, 024253-17, 027699-17, 017145-18, 026625-18, 030116-18	Critical Incident System

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

FARAH_ KHAN (695)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): December 5, 6, 7, 10, 11, and 12, 2018

During the course of the inspection, the following Critical Incident (CI) intakes were inspected:
Intake #021687-17, related to staff to resident alledged abuse
Intake #017145-18, related to staff to resident alledged abuse
Intake #024253-17, related to improper treatment of a resident
Intake #027699-17, related to a fall with injury
Intake #026625-18, related to a fall with injury
Intake #030116-18, related to a medication error

During the course of the inspection the inspector observed the provision of care and services, and reviewed relevant documents including: clinical records, policies and procedures and meeting minutes.

During the course of the inspection, the inspector(s) spoke with residents, personal support workers (PSW), dietary aide, registered practical nurses (RPN), registered nurses (RN), the Director of Care and the Administrator.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
4 WN(s)
2 VPC(s)
1 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 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with s. 114 (2) the licensee shall ensure that written policies and protocols were 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.

a) A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC) which stated that resident #001 experienced certain symptoms a period of time after the resident was readmitted from hospital. The home's physician reviewed the last hospital readmission medication and identified that there was a medication reconciliation error.

A clinical review of resident #001's chart found that there was a medication reconciliation error when resident #001 returned from hospital in 2018.

According to the policy titled "Medication Reconciliation," when a resident returned from hospital, staff were directed to complete a specific process for medication reconciliation.

The DOC confirmed that there was an error in medication reconciliation.

b) Resident #001 was hospitalized again later in 2018.

The medication reconciliation process was reviewed and an error was identified.

Registered Nurse #109 acknowledged that changes in timing to medications were expected to be reviewed by the physician upon return from hospital during the medication reconciliation process. The RN confirmed that it was not done in this case.

The licensee failed to ensure the policies and protocols for the medication management system were complied with, specifically that the medication reconciliation process was followed when resident #001 returned from hospital on two occasions. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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).

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).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident’s care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the resident.

A CI was submitted to the MOHLTC related to resident #003 falling and sustaining an injury.

The current written plan of care for the resident in the falls interventions section directed staff to clip the call bell on a certain area of the bed.

Resident #003 was observed lying in bed with the call bell on the floor. Personal Support

Worker (PSW) #101 acknowledged that the call bell was on the floor and stated that it should be with the resident.

Registered Nurse (RN) #110 confirmed that the residents' written plan of care stated to pin the call bell to a specific area of the bed that the resident no longer had.

The licensee failed to ensure that the plan of care for resident #003 set out clear directions to staff and others who provided direct care to the resident regarding where to place the call bell when the resident was in bed. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A CI was submitted to the MOHLTC which stated that resident #006 was left on the toilet for an extended period of time.

Upon review of the residents written plan of care under the toileting section, it stated that staff should be present at all times.

Personal Support Worker (PSW) #118 stated that they would always stay close by if resident #006 was on the toilet.

The Director of Care (DOC) acknowledged that it was expected that staff supervised resident #006 while on the toilet and that it was not done in this case.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #006 as specified in the plan, specifically that staff were present at all times when the resident was on the toilet. [s. 6. (7)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

The most recent Falls Risk Assessment was reviewed for resident #003 and indicated that the resident was at a different level of risk for falls than previous.

In separate interviews with PSW #100, RPN #103, and RPN #106, it was said that a specific coloured symbol was indicated for the resident who was at high risk for falls.

Personal Support Worker #100 explained that it alerted staff to monitor the resident more and ensure that they are mobilizing and transferring appropriately.

A certain area of resident #003's room was observed to have a specific colored symbol for falls risk.

Registered Nurse #110 confirmed that the resident's symbol should have been changed to indicate a change in their fall risk level.

The licensee has failed to ensure that the resident's plan of care was reviewed and revised, when resident 003's care needs changed, specifically that the symbol was updated to alert staff that the residents risk for falls had changed. [s. 6. (10) (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 the care set out in the plan of care is provided to the resident as specified in the plan, 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. (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 has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Resident #001 was prescribed a medication to be applied at a specific time and removed at a specific time daily. According to the progress note RPN #111 observed resident #001 to have two dosing mechanisms applied.

The medication incident report completed stated that RPN #106 was supposed to remove the dosing mechanism but instead applied another one and that is how RPN #111 discovered two on the residents body.

Registered Practical Nurse #106 acknowledged that the incident occurred.

The DOC acknowledged that the medication was applied instead of removed as per the doctor's order.

The licensee has failed to ensure that a particular medication was administered to resident #001 in accordance with the directions for use specified by the prescriber. [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 #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident’s money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director.

A CI was submitted to the MOHLTC for emotional abuse a period of time after the incident occurred.

Dietary aide #112 stated they witnessed the incident and reported it a period of time after it occurred.

The DOC confirmed that the staff member who witnessed the incident did not report the suspected abuse immediately and that the CI was submitted to the Director a period of time after the events took place.

The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse occurred to resident #005 by PSW #121 immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 28th day of December, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	FARAH_ KHAN (695)
Inspection No. / No de l'inspection :	2018_727695_0017
Log No. / No de registre :	021687-17, 024253-17, 027699-17, 017145-18, 026625-18, 030116-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 27, 2018
Licensee / Titulaire de permis :	Chartwell Master Care LP 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	Chartwell Elmira Long Term Care Residence 11 Herbert Street, Elmira, ON, N3B-2B8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Matthew Bombardier

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) of O. Reg. 79/10.
Specifically, the licensee must:
a) Ensure that staff follow the home's policy regarding the medication reconciliation process.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

In accordance with s. 114 (2) the licensee shall ensure that written policies and protocols were 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.

a) A Critical Incident (CI) was submitted to the Ministry of Health and Long Term Care (MOHLTC) which stated that resident #001 experienced certain symptoms a period of time after the resident was readmitted from hospital. The home's physician reviewed the last hospital readmission medication and identified that there was a medication reconciliation error.

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The DOC confirmed that there was an error in medication reconciliation.

b) Resident #001 was hospitalized again later in 2018.

The medication reconciliation process was reviewed and an error was identified.

Registered Nurse #109 acknowledged that changes in timing to medications were expected to be reviewed by the physician upon return from hospital during the medication reconciliation process. The RN confirmed that it was not done in this case.

The licensee failed to ensure the policies and protocols for the medication management system were complied with, specifically that the medication reconciliation process was followed when resident #001 returned from hospital on two occasions. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2, minimal harm or potential for actual harm. The scope of the issue was level 2, pattern. This area of non-compliance is a key risk indicator. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 28, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of December, 2018

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Farah_ Khan

Service Area Office / Bureau régional de services : Central West Service Area Office