Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspection Branch

**London District**
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

# Original Public Report

| |
|---|
| **Report Issue Date:** February 22, 2023 |
| **Inspection Number:** 2023-1141-0001 |
| **Inspection Type:**<br>Complaint<br>Critical Incident System |
| **Licensee:** Chartwell Master Care LP |
| **Long Term Care Home and City:** Chartwell Parkhill Long Term Care Residence, Parkhill |

| **Lead Inspector** | **Inspector Digital Signature** |
|---|---|
| Cheryl McFadden (745) | Cheryl McFadden Digitally signed by Cheryl McFadden Date: 2023.02.22 15:15:39 -05'00' |

**Additional Inspector(s)**
Tatiana Pyper (733564)

## INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 27, 30, 31 and February 2, 3, 6 and 7, 2023.

The following intake(s) were inspected:

- Intake: #00002480-[IL: IL-03639-LO] complainant related to resident neglect, 24-hour nursing care, medication management and lack of social activities.
- Intake: #00006076-[CI: 2632-000018-22] related to fall's prevention and management.
- Intake: #00006936-[CI: 2632-000010-22] related to fall's prevention and management.
- Intake: #00007265-[AH: IL-05310-AH/CI: 2632-000019-22] responsive behaviours and resident to resident abuse.
- Intake: #00014749-IL-07783-LO/IL-07934-LO: complaint, related to alleged sexual abuse.

The following **Inspection Protocols** were used during this inspection:

Staffing, Training and Care Standards
Medication Management
Safe and Secure Home
Responsive Behaviours
Prevention of Abuse and Neglect
Infection Prevention and Control
Falls Prevention and Management
Resident Care and Support Services

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: ADMINISTRATION OF DRUGS

**NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 140 (1)

The Licensee has failed to ensure that no drug was administered to a resident unless the drug had been prescribed for the resident.

**Rationale and Summary**

A complaint to the Ministry of Long-Term Care Info Line, reported a resident had received medication not prescribed for them.

Review of resident clinical records showed, they had been administered multiple medications in error, without any ill effects from the medication they had received.

Director of Care stated that they were aware staff administered multiple medications to a resident, which were not prescribed for them. Director of Care acknowledged staff did not verify the resident's identity using two patient identifiers prior to administering the medication.

The medication given in error to a resident, had created risk for potential ill effects.

Sources: Info Line Complaint; review of resident clinical records, and interview with Director of Care [733564]

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

**NC ##002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O.Reg. 246/22, s. 96 (2) (b)

Maintenance services

Non-compliance with: O. Reg. 246/22 s. 96 (2) (b)

The licensee has failed 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, excluding the residents' personal aids or equipment.

A complaint was reported to the Ministry of Long-Term Care regarding suction machines available in the two home areas that were not in working condition.

Personal Support Worker and a Registered Nurse stated the two suction machines available in the home were not in working condition and had not been in working condition for a while. They also stated that the management had been aware on multiple occasions that the suction machines were not in working condition.

Personal Support Worker and a Registered Nurse stated that on two occasions the suctioning machines were required to assist residents and they were not working properly.

ADOC stated that they were aware that both suction machines available in the home were not in proper working condition on two occasions when they were needed.

Director of Care stated they were aware the suction machines in the home were not in proper working condition and they have been serviced and are now in working order.

The home not having suction machines available in the home in working condition could have contributed to an aggravation of residents' medical conditions when they required removal of respiratory secretions.

Sources: Info Line Complaint, review of clinical records for two residents, observations in the home, interview with PSW, RN, ADOC, and DOC. [733564]

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