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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2017	2017_262630_0028	022934-17	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 London Long Term Care Residence
2000 Blackwater Road LONDON ON N5X 4K6

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

AMIE GIBBS-WARD (630), HELENE DESABRAIS (615)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 10, 11, 12 and 13, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Critical Incident Log #019011-16 for Critical Incident System (CIS) report 2919-000003-16 related to falls prevention;
Critical Incident Log #019144-16 for Critical Incident System (CIS) report 2919-000005-16 related to falls prevention;
Critical Incident Log #010250-16 for Critical Incident System (CIS) report 2919-000007-16 related to alleged abuse;
Critical Incident Log #029148-16 for Critical Incident System (CIS) report 2919-000028-16 related to falls prevention;
Critical Incident Log #008164-17 for Critical Incident System (CIS) report 2919-000011-17 related to medication management;
Critical Incident Log #008263-17 for Critical Incident System (CIS) report 2919-000012-17 related to medication management;
Critical Incident Log #009107-17 for Critical Incident System (CIS) report 2919-000015-17 related to medication management;
Critical Incident Log #021772-17 for Critical Incident System (CIS) report 2919-000021-17 related to falls prevention.

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, a Resident Care Services Consultant, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), a Housekeeper, family members and over twenty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed various policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **2 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	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. 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 was reported to the resident, the resident's Substitute Decision Maker (SDM), 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.

The home submitted two Critical Incident System (CIS) reports to the Ministry of Health and Long Term Care (MOHLTC) which were related to missing medications. A review of these reports found that both incidents documented that the physician, relatives, friends, designated contacts and/or SDMs were not contacted.

A review of the home’s Medication Incident Reports found that for a three month time period, seven medication incidents involving residents occurred. According to the medication incident reports, only the Assistant Director Of Care (ADOC) was notified of the incidents.

The home's "Medication Incidents" policy #LTC-CA-WQ-200-06-11, reviewed January 2017, stated "Registered staff finding or involved in a medication error that involves a resident must: report the medication error to the Director of Care or designate, Physician/Nurse Practitioner and when appropriate to the pharmacist; if the resident has been transferred to hospital notify the Director of Care or designate immediately and ensure all documentation is completed to facilitate the completion of the Critical Incident Report Form".

During interviews with identified staff it was reported that if a medication error or incident involving a resident occurred then the family, DOC, physicians and pharmacy should be notified.

During an interview, acting Director of Care (aDOC) stated that the seven medication incidents were not reported to the SDMs, 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 as per the regulations.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [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 by ensuring that every medication incident involving a resident and every adverse drug reaction is 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, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of housekeeping, procedures were developed and implemented for the cleaning and disinfection of devices including personal assistance services devices.

Multiple observations during the Resident Quality Inspection (RQI) found the assistive devices for two identified residents were dirty.

During an interview with an identified staff member it was reported that resident assistive devices were cleaned on the night shift by staff based on the schedule. This staff member said that there was a binder with the schedule for cleaning and the staff signed off once per month when the assistive devices were cleaned. This staff member observed the assistive device for one of the identified residents with the inspector and acknowledged that it was dirty.

The acting Director of Care (aDOC) observed the assistive device for one of the identified residents and acknowledged that it was dirty.

During an interview the aDOC and Resident Care Services Consultant said that there was a process in the home for cleaning assistive devices. They said the process was outlined in the "Long Term Care (LTC) Staff Guide Book February 2017" and it was the expectation that staff would follow this procedure which directed that assistive devices would be cleaned weekly with a low level disinfectant. The Resident Care Services Consultant said that the assistive devices cleaning schedule that had been implemented in the home was based on a monthly schedule for cleaning and for that reason staff were only signing as having cleaned the devices monthly. The Resident Care Services Consultant said that the procedures in the home needed to be reviewed and revised to ensure staff were implementing the weekly assistive devices cleaning as this was the expected procedure in the home.

The severity was determined to be a level one as there was minimal risk. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 87. (2) (b)]

Issued on this 7th day of November, 2017

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

Original report signed by the inspector.