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
May 24, 2018	2018_263524_0007	005670-18	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

INA REYNOLDS (524), AMIE GIBBS-WARD (630), DONNA TIERNEY (569), JULIE LAMPMAN (522)

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): May 7, 8, 9, 10, 11, 14, 15 and 16, 2018.

The following intakes were completed within the Resident Quality Inspection:
Log #012122-16 / Critical Incident System #2919-000012-16 related to falls prevention
Log #014380-16 / Critical Incident System #2919-000014-16 related to allegation of abuse

Log #019172-16 / Critical Incident System #2919-000020-16 related to allegations of abuse
Log #019825-16 / Critical Incident System #2919-000021-16 related to allegations of abuse
Log #023542-16 / Critical Incident System #2919-000025-16 related to allegations of abuse
Log #023608-16 / Critical Incident System #2919-000024-16 related to allegations of abuse
Log #032388-16 / Critical Incident System #2919-000031-16 related to allegations of abuse
Log #023603-17 / Critical Incident System #2919-000027-17 related to allegations of abuse
Log #024280-17 / Critical Incident System #2919-000024-17 related to medications incident
Log #026711-17 / Complaint #IL-54231-LO related to allegations of neglect, continence care and personal support services
Log #002623-18 / Critical Incident System #2919-000002-18 related to falls prevention.

The following intake was inspected at the same time as the Resident Quality Inspection and can be found in a separate report:
Log #017977-16 / Complaint #IL-017977-LO related to nutrition care and personal support services.

The following inquiries were completed:
Log #023006-17 / Critical Incident System #2919-000022-17 related to allegations of abuse
Log #023622-17 / Critical Incident System #2919-000025-17 related to allegations of abuse
Log #026934-17 / Critical Incident System #2919-000028-17 related to misuse/misappropriation of funds
Log #024637-17 / Critical Incident System #2919-000026-17 related to allegations of abuse
Log #006524-18 / Complaint #IL-56276-LO related to falls prevention management, bedrails and supplies.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Environmental Manager,

the Program and Support Services Manager, the Registered Dietitian, the Resident Assessment Instrument Coordinator, two Registered Nurses, four Registered Practical Nurses, fifteen Personal Support Workers, one Maintenance Technician, one Dietary Aide, two Housekeeping Aides, one Activation Aide, one Private Caregiver, the Residents' Council Representative, the Family Council Representative, residents and family members.

The inspector(s) also conducted a tour of the home, observed resident care provisions, resident and staff interactions, dining services, medication administration, a medication storage area, infection prevention and control practices, and the general maintenance, cleanliness and condition of the home. Inspectors reviewed residents' clinical records, postings of required information, relevant meeting minutes, internal investigation notes, medication incident reports, and relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **8 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other.

During stage one of the Resident Quality Inspection an identified resident was noted as having altered skin integrity.

Review of the resident's current care plan noted a skin focus which stated the resident had altered skin integrity on a specific part of their body. However, review of the resident's Minimum Data Set (MDS) Assessment, noted the resident had altered skin integrity on a different area of their body. Review of the resident's progress note

identified inconsistencies in the specific areas of altered skin integrity between the Dietary MDS Supplement note and the doctor's orders note. In addition, a review of the resident's electronic assessments in Point Click Care noted inconsistencies documented related to skin and wound assessments.

In an interview on a specific date and time, the Registered Practical Nurse - Wound Care Champion (RPN-WCC) stated that the resident had an area of altered skin integrity on a specific part of their body. The RPN-WCC stated that staff must have changed the wording in their assessments as the resident did not have altered skin integrity on any other areas.

In an interview on a specific date and time, the Director of Care stated that the wording in the assessments needed to be clear as the way the assessments currently read, it would look like the resident had pressure ulcers in different areas.

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

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

During stage one of the Resident Quality Inspection an identified resident was noted as having altered skin integrity on a specific part of their body.

Review of the resident’s doctor’s orders noted that a pain assessment was to be completed before and after a specific treatment. A review of the resident’s electronic pain assessments in Point Click Care noted assessments were not completed on numerous occasions. The resident was present in the home during this time.

In an interview on a specific date and time, the Registered Practical Nurse - Wound Care Champion (RPN-WCC) stated the pain assessments had not been completed and they should have been completed during the treatment. In an interview on a specific date and time, the Director of Care stated pain assessments should have been completed for the resident.

The licensee has 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)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care were documented.

During stage one of the Resident Quality Inspection an identified resident was noted as having altered skin integrity on a specific part of their body.

Review of the resident’s current care plan under the skin integrity focus directed staff to ensure the resident was turned and repositioned at specific times to maintain skin integrity. Specific care plan interventions were also noted under the focus for pain to reduce/relieve pain and promote comfort and skin integrity. Review of documentation in Point of Care for the identified resident noted turning and repositioning was not documented during all shifts.

In an interview on a specific date and time, a Personal Support Worker stated that staff used to document when the resident was turned and repositioned throughout the shifts but this was no longer done.

In an interview on specific date and time, the Director of Care stated staff would not necessarily be expected to document turning and repositioning.

The licensee has failed to ensure that the provision of the care set out in the plan of care were documented. [s. 6. (9) 1.]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

During stage one of the Resident Quality Inspection an identified resident was noted as having an area of altered skin integrity to a specific part of their body.

Review of the resident’s doctor’s orders noted specific directions related to the treatment of the area of altered skin integrity.

On a specific date and time, during observation of the resident’s skin care, a Registered Nurse stated that staff were no longer following the doctor's orders as the specific treatment was no longer needed.

In an interview on a specific date and time, the Registered Practical Nurse - Wound Care Champion (RPN-WCC) stated that the area of altered skin integrity had gotten better. In an interview on a specific date and time, the Director of Care stated that the resident's doctor's order would need to be updated. The DOC stated that the order needed to be reflective of what staff were actually providing.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary. [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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; to ensure that the care set out in the plan of care is provided to the resident as specified in the plan; to ensure that the provision of care set out in the plan of care is documented; and, to 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 the resident's care needs changed or care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

During the initial tour of the home on a specific date and time, a housekeeping room was observed unlocked on an identified resident home area. The housekeeping room was located directly across from the resident dining area.

In an interview, a Housekeeping Aide (HA) confirmed the door was unlocked and stated the door should be locked.

At a specific time, a soiled utility room was observed unlocked on an identified resident home area.

In an interview, a Personal Support Worker (PSW) stated the door should be locked and a code was to be used to unlock the door. The PSW tried the door and it did not open. The PSW used the code to enter the room and when they left and closed the door, the inspector was able to open the door again. The PSW confirmed that the door did not lock and stated they would have maintenance check the door.

An another identified housekeeping room on a specific unit was observed unlocked. The housekeeping room was located directly across from the resident dining area. A PSW confirmed the door was open and should be locked.

A Housekeeping Aide (HA) entered the housekeeping room while the inspector was inside. The inspector informed the HA that the door was unlocked. The HA stated the door should be locked and it was locked when they had left the room.

At a specific time, an identified soiled utility and electrical closet room on a identified unit was observed unlocked.

In an interview, a Registered Practical Nurse (RPN) confirmed the door was unlocked and stated the door should be locked but was unable to lock the door. The RPN stated a PSW had informed them that the soiled utility room on the other unit also had issues with locking and a request had been put into maintenance.

On another date and time, an identified housekeeping room on a resident home area was observed unlocked. The inspector spoke with a PSW who stated the door should be locked. The PSW called the Maintenance Technician (MT) who was passing by. The MT tried the door and confirmed there was an issue with the lock and stated a part had been ordered. The MT pulled the door shut and the lock engaged.

In an interview on a specific date, the Environmental Manager (EM) stated the doors to the soiled utility rooms and housekeeping rooms should be locked. The EM stated there was an issue with the codes on the doors and they had ordered new locks for each door to be replaced today.

In an interview on a specific date, the Administrator stated staff should be checking that the doors were locked behind them when they leave a room, as this was standard practice. The Administrator also stated that when staff identify an issue with locks that it should be reported immediately to maintenance.

The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's communication abilities including hearing and language.

Record review of the Minimum Data Set (MDS) assessment and Resident Assessment Protocol (RAP) summary for a specific date, under the communication section for an identified resident indicated the resident had a number of communication problems. The triggered Resident Assessment Protocol (RAP) notes indicated that the communication problem would be addressed in the care plan. The RAP notes stated that the resident was "responding to the interventions as outlined in the care plan" and their clinical assessment had not changed from the last assessment. The RAP note further stated that the resident's care plan goals and interventions had been reviewed by the care team members and continued to be effective in maintaining the RAP problem.

Record review of the most recent plan of care on Point Click Care for the resident indicated there was no focus statement, goals or interventions with respect to the resident's communication abilities and needs based on the assessment.

Interview with a Personal Support Worker (PSW) verified that the resident had a communication problem and staff had trouble understanding them related to their diagnosis. The PSW said that the resident had difficulties making their care needs known to staff and they could become very frustrated.

Staff interview with the Director of Care on a specific date, acknowledged that there was no communication focus in the plan of care that identified strategies to address the communication problems for the resident as identified in the MDS and there should have been, so that anyone could look at the care plan to determine how to communicate with the resident. [s. 26. (3) 3.]

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 a plan of care is based on, at a minimum, an interdisciplinary assessment of the resident's communication abilities including hearing and language, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

During stage one of the Resident Quality Inspection and in a later interview on a specific date, an identified resident stated that they had altered skin integrity.

Review of the resident's Initial Skin and Wound Full Assessment on a specific date, indicated the resident had altered skin integrity and had no pain. The remainder of the assessment was blank, including the reason for the assessment, interventions, referrals for assessment and the description and measurements of the altered area.

A review of the resident's current care plan did not include a focus related to the altered skin integrity.

In an interview on a specific date, a Registered Nurse stated that they were not aware that the resident had altered skin integrity to an area of their body.

In an interview on specific date,the Director of Care stated that the resident's skin assessment was not completed and there should have been a notation in the resident's care plan related to the altered skin integrity. The DOC stated that nursing staff should have completed further follow up with the resident and that if the resident's altered skin integrity had resolved that there should be a notation in the resident's progress note.

The licensee has failed to ensure that a resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

During the initial tour of the home on a specific date and time, an identified housekeeping room was observed unlocked on a specific resident home area. The housekeeping room was located directly across from the resident dining area.

The cupboards below the sink were observed unlocked. One cupboard contained a four litre (L) bottle of Total Universal Cleaner and Polish. The label indicated it was toxic to skin, eyes, inhalation and ingestion. There was an Easy Scrub pour jug and a container of unknown clear liquid in an Easy Scrub express caddy. A container of Sabre wipes-cleaner, disinfectant, sanitizer, bactericidal and general barbicide, four containers of hygenipak unscented foaming skin cleanser, and five containers of Microsan optidose foaming alcohol hand soap. Another cupboard contained two 1L bottles of Vert-2-Go Bio washroom cleaner and deodorizer, Aloemed foam hand sanitizer, Microsan encore foaming alcohol hand rub, and three 3L bottles of Vert-2-Go Oxy neutral cleaner which was noted on the label as toxic.

In an interview, a Housekeeping Aide (HA) confirmed the door was unlocked and stated the door should be locked.

At a specific time, an identified soiled utility room was observed unlocked on a resident home area. Inside the room the cupboard door was observed unlocked and contained a bottle of Everyday disinfectant.

In an interview, a Personal Support Worker (PSW) stated the door should be locked and a code was to be used to unlock the door. The PSW tried the door and it did not open. The PSW used the code to enter the room and when they left and closed the door the inspector was able to open the door again. The PSW confirmed that the door did not lock and stated they would have maintenance check the door.

An identified Housekeeping room on another unit was observed unlocked. The housekeeping room was located directly across from the resident dining area. A PSW confirmed the door was open and should be locked.

On the counter was a bottle of Everyday cleanser and AloeMed foam hand sanitizer. The cupboard below was observed unlocked and contained a 5L bottle of Sodium Hypochlorite, which stated on the label danger for eyes and skin, 1.89L of concentrated bleach, Laundry soap fluff 200, eight 1L Microsan Oxidise containers, four 1L containers of Hygenipak unscented foaming skin cleanser, one 4L bottle of N'odor, two 4L bottles of Total Universal Cleaner and Polish and an Easy scrub pour jug.

The doors to the chemical dispensing units on the wall were observed unlocked and ajar. The units contained a 3L Vert-2-Go Oxy, 3L Vert-2-Go glass cleaner, 3L Vert-2-Go bio and 3L Everyday disinfectant.

A Housekeeping Aide (HA) entered the housekeeping room while the inspector was inside. The inspector informed the HA that the door was unlocked.The HA stated the door should be locked and it was locked when they had left the room.

At a specific time, an identified soiled utility and electrical closet room on an identified unit was observed unlocked. The upper cupboard was observed unlocked with a bottle of Everyday disinfectant inside. In an interview, a Registered Practical Nurse confirmed the door was unlocked and stated the door should be locked but was unable to lock the door. The RPN stated a PSW had informed them that the soiled utility room on another unit also had issues with locking and a request had been put into maintenance.

On a specific date and time, an identified housekeeping room on a specific resident home area was observed unlocked. Chemicals were again accessible. The inspector spoke with a PSW who stated the door should be locked. The PSW called the Maintenance Technician (MT) who was passing by. The MT tried the door and confirmed there was an issue with the lock and stated a part had been ordered. The MT pulled the door shut and the lock engaged.

In an interview on a specific date, the Environmental Manager (EM) stated the doors should be locked and chemicals should not be accessible.

The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times. [s. 91.]

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 all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: 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. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident.

During the Resident Quality Inspection medication incidents and adverse drug reactions were reviewed for the period of October to December 2017.

A review of a medication incident report noted that on a specific date and time, an identified resident was given a medication that was not ordered for that resident. The medication incident was discovered at a specific time, by the Registered Practical Nurse (RPN) when they were going through the narcotics. The medication incident report stated the medication was the same colour as the medication which was to be given to the resident and the card with the medication was in the narcotic box before the resident's name.

In a phone interview on a specific date, the RPN stated that the incident occurred on a specific shift and if they remembered correctly it was a distraction error as there were residents around the medication cart. The RPN stated they had mistakenly grabbed the card with the medication for another resident instead of the narcotic for the identified resident. The RPN stated there were no negative effects to the resident as a result of the medication error.

In an interview on a specific date, the DOC acknowledged that medications should be given as prescribed.

The licensee has failed to ensure that no drug was administered to a resident in the home unless the drug had been prescribed for the resident. [s. 131. (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 no drug is administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #7: 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).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and, (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.

During the Resident Quality Inspection medication incidents and adverse drug reactions were reviewed for the period of October to December 2017.

A) A review of a medication incident report noted that on a specific date and time, an identified resident was given a medication that was not ordered for that resident. The

medication incident was discovered at a specific time, by the Registered Practical Nurse (RPN) when they were going through the narcotics.

The medication incident report did not contain the immediate actions that were taken to assess and maintain the resident's health.

In a phone interview on a specific date and time, the RPN stated that they thought they had taken the resident's vitals.

In a phone interview on a specific date, a Registered Nurse (RN) who was acting Assistant Director of Care during that time period, stated the registered staff would have completed vitals and monitored the resident for any changes.

In an interview on a specific date, the Director of Care (DOC) confirmed the immediate interventions taken to assess and maintain the resident's health were not documented on the medication incident report and stated this should have been documented on the medication incident report.

B) A review of a Critical Incident System report submitted to the Ministry of Health and Long-Term Care by the home noted on a specific date and time a medication incident.

A review of the medication incident report noted that the date and time the medication incident was reported to the resident or resident's substitute decision maker, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician and the pharmacy service provider was not documented.

The medication incident report also did not include the resident outcome, type of incident, causes and contributing factors relating to the incident.

In a phone interview on a specific date, the RN who was acting Assistant Director of Care during that time period, stated they had completed the medication incident report and they should have documented the date and time of when the medication incident was reported to the resident's substitute decision maker, the attending physician, who was also the Medical Director and prescriber, the Director of Care and the pharmacy service provider. The identified RPN stated they thought they had completed all of the required documentation on the report and stated the resident outcome, type of incident, causes and contributing factors relating to the incident should have been documented.

In an interview on a specific date, the DOC confirmed the medication incident report did not indicate the date and time of when the medication incident was reported and should have. The DOC also confirmed the medication incident report did not include the resident outcome, type of incident, causes and contributing factors relating to the incident and should have.

The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was, (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and (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. [s. 135. (1)]

2. The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b).

During the Resident Quality Inspection medication incidents and adverse drug reactions were reviewed for the period of October to December 2017.

A) A review of a medication incident report noted that on a specific date and time, an identified resident was given medication that was not ordered for that resident. The medication incident was discovered at a specific time by the Registered Practical Nurse (RPN) when they were going through the narcotics.

A review of the medication incident report noted no documented evidence of corrective action taken.

In a phone interview on a specific date, the Registered Practical Nurse (RPN) stated they thought the Assistant Director of Care (ADOC) had spoken to them after the incident and the ADOC stated that they needed to be more careful as this could have been serious. The RPN stated that they did not complete any re-education.

In a phone interview on a specific date, the Registered Nurse (RN) who was acting ADOC during that time period, stated they had spoken with the RPN about the rights of administering medications. The RN stated they did not believe they had documented the

follow-up with the RPN.

In an interview on a specific date, the Director of Care (DOC) confirmed the corrective action taken was not documented on the medication incident report and stated this should have been documented.

B) A Review of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care by the home noted a medication incident on a specific date and time.

A review of the medication incident report and the London Police Service Summary Incident report noted that the police had been notified of the medication incident. A review of the CIS report, the home's medication incident report and Chartwell's Investigation Form noted no further documentation related to the outcome of the police notification or if the police investigated the incident.

In an interview on a specific date, the Administrator stated they received an email from the police confirming that the online report had been received but there was no further follow-up from the police. The Administrator acknowledged that this should have been indicated on the medication incident report.

The licensee has failed to ensure that, (a) all medication incidents and adverse drug reactions were documented, reviewed and analyzed; (b) corrective action was taken as necessary; and (c) a written record was kept of everything required under clauses (a) and (b). [s. 135. (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 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 (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; and, to ensure that, (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; (b) corrective action is taken as necessary; and (c) a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored and the symptoms were recorded and that immediate action was taken as required.

An identified resident had a respiratory infection according to the most recent Minimum Data Set (MDS) assessment.

Review of the clinical record in Point Click Care (PCC) for the resident showed that on a specific date and time, a Nurse Practitioner was asked to see the resident related to specific symptoms and not feeling well. The resident was assessed and on the same

day at a specific time, an Infection Note stated the resident was initiated on an identified medication for a number of days. The notes continued to state that the resident would have ongoing monitoring completed by registered staff and the Infection Control Coordinator. In addition, a Multidisciplinary Progress Note on a specific date and time, indicated that the resident was also ordered another medication for a number of days.

On a specific date, an inspector interviewed the Assistant Director of Care (ADOC) who was also the lead for the infection control program. The ADOC said the process for any resident showing respiratory symptoms would be to isolate the resident in their room and start the resident on antibiotics, if required. The resident’s symptoms were then monitored and documented on the Daily Infection Surveillance Tracking form and in the progress notes. The ADOC also added that registered staff were required to document the vital signs in the progress notes on each shift.

Record review of the home's Daily Infection Surveillance Tracking forms for a specific time period, showed there was not always documentation on the Daily Infection Surveillance Tracking of the respiratory symptoms on every shift.

A review of the home’s policy titled "Daily Infection Surveillance" LTC-CA-WQ-205-03-02 with a revision date of November 2017, outlined that “at the beginning of each shift, Registered Staff will review shift report and daily surveillance records to identify residents with infectious symptoms when making their rounds of the unit" and "will observe and assess residents for signs and symptoms of illness or possible infection. When symptoms are identified, Registered Staff is to record the resident name and room number on the Daily Infection Surveillance Form following the legend on the form. Subsequent shifts are to continue assessing and observing residents with symptoms recording findings using the legend on the Daily Infection Surveillance Form.”

In an interview on a specific date, the ADOC acknowledged there was missing documentation related to the resident's respiratory infection and their symptoms were not always recorded on every shift.

The licensee has failed to ensure that for a specific period of time, symptoms indicating the presence of infection for an identified resident were monitored and recorded on every shift. [s. 229. (5) (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 on every shift, symptoms indicating the presence of infection in residents are monitored and the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the investigation were reported to the Director.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted by the home on a specific date, which identified an incident of alleged staff to resident abuse that occurred on a specific date. The home conducted an internal investigation and follow-up actions were initiated with the staff member involved.

The CIS report showed that the Central Intake and Assessment Triage Team (CIATT) had requested an update of the report on a specific date, for the home to amend the CIS with the outcome of the investigation. This report did not include the requested information.

Inspector reviewed the Long-Term Care Homes Critical Incident System, used by the home to report incidents to the Director, and found no amended CIS report.

On a specific date, the Administrator acknowledged to the inspector that the results of the verbal abuse investigation completed were not reported to the Director. The Administrator said that since that time the process had changed and the home now had a better internal tracking system.

The licensee has failed to ensure that the results of the alleged verbal abuse investigation were reported to the Director. [s. 23. (2)]

Issued on this 9th day of July, 2018

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

Original report signed by the inspector.