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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 11, 2017	2017_677126_0008	027324-16, 035394-16, 000298-17	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 Champlain Long Term Care Residence
428 Front Road West L'Orignal ON K0B 1K0

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

LINDA HARKINS (126)

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): June 8, 9, 12, 13, 2017

During this inspection the following were inspected:
Log #027324-16: Unexpected Death
Log #035394-16: Incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status
Log #000298-17: Controlled Substance Missing/unaccounted

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the home's Pharmacist and one resident. During the course of the inspection, Inspector #126 observed care and services provided to residents, reviewed three resident's health care records, reviewed a medication policy, reviewed the staffing work schedules, reviewed the "unit daily record" , reviewed emails correspondence between the DOC and the Pharmacist, and reviewed "Medication Administration Record".

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 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 a medicated patch was administered to resident # 001 in accordance with the directions for use specified by the prescriber.

On a specific date in September 2015, resident #001's was prescribed a medication patch "every 72 hours, please removed old patch before applying new one ".

On specific date in August 2016, it was documented on the Medication Administration Record, that Registered Nurse(RN) #100 applied the medication patch on resident #001 in the evening as per the physician order.

Three days later, in August 2016, the family physician modified resident's #001's medication and prescribed to stop the medication patch. On that same day in August 2016, in the afternoon, RN #100 processed that family physician order. Resident's # 001's health care record was reviewed and no documentation was located related to the removal of the medication patch on that specific day in August 2016.

On June 8, 2017, during an interview, the Director OF Care (DOC) indicated to Inspector #126 that resident #001's family informed the Administrator that when resident #001 was sent to the hospital, the hospital staff noted that resident #001 still had a "patch"on the back dated a specific date of August 2016. The DOC indicated that he had a discussion with the family physician related to the medication patch that was not removed. The family physician, who also work in the Emergency Room,indicated that the cause of death of resident #001 was not related to the medicated patch.

The DOC investigated the incident related to not removing the medication patch on resident #001 in August 2016. The DOC reviewed the August 2016 Medication Administration Record (MAR) and noted that the removal of the patch section was discontinued on that specific date in August 2016 because on that day, Registered Practical Nurse (RPN) #101 contacted the physician to inform him that resident # 001 removed the medication patch and needed a new order to re-apply a new patch. At that time, there was no longer a trigger in the system, for the nurses to remove the medication patch. The DOC discussed with RN #100, who indicated that she did not removed the medication patch on that specific date in August, 2016, because she wanted to wait for the new medication to arrive from pharmacy.

Following that incident, the DOC contacted the pharmacy and the licensee to review the policy related to Transdermal Patches (TP). He indicated that a new medication policy was implemented, that education was provided to registered nursing staff and that the pharmacy brought to their attention the proper procedure for entering orders of TP.

Inspector #126 was not able to interview RN #100 as she no longer work in the home.

On that specific date of August 2016, the family physician ordered to stop the medication patch and the patch was not removed at that time by RN#100. [s. 131. (2)]

Issued on this 11th day of July, 2017

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

Original report signed by the inspector.