



**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 rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 27, 2017	2017_683126_0020	019224-17	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 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), JOANNE HENRIE (550)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): November 20, 21, 22, 23, 24, 2017

During this inspection a Critical Incident log # 015461-17 was inspected.

During the course of the inspection, the inspector(s) spoke with the Administrator \Director of Care, the Assistant Director of Care, several Registered Nurses, several Registered Practical Nurses, several Personal Support Workers, several residents, several family members and the President of the Resident Council.

The following Inspection Protocols were used during this inspection:

Contenance Care and Bowel Management

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Residents' Council

Skin and Wound Care

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	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

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 is complied with.

In accordance with O. Reg. 79/10, s. 114. (2) The licensee shall ensure that written policies and protocols are 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.

The licensee Medication Administration, LTC-CA-WQ-200-06-01, revision date of April 2017 requires under Procedure: "12. Administer the medication as close to the schedule time as possible and within 1 hour before or after the designated time".

On November 23, 2017, Inspector #126 observed a medication pass done by Registered Nurse #100. RN #100 was observed administering several medications to resident #022 which included analgesic.

On November 23, RN#100 indicated that she was late passing the morning medication pass as she was in a meeting with the Administrator which lasted longer than expected.

On November 23, 2017, during the medication pass, Inspector #126 noted that the administration time for the above medications were to be administered at a specified time 3.75 hours earlier.

RN #100 failed to follow the medication administration policy to ensure to administer the medication "as close to the scheduled time as possible within 1 hours after the designated time". All these medications were administered 3.75 hours after the designated time. [s. 8. (1) (b)]



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Issued on this 28th day of November, 2017

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

Original report signed by the inspector.