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
Jun 22, 2018	2018_683126_0011	010763-18	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 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), MELANIE SARRAZIN (592)

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): June 4, 5, 6, 7, 8, 2018

During this inspection the following inspection was conducted:
Log #008271-18: Complaint related to care and services

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

The inspectors reviewed resident health care records, documents related to the medication management system and information pertaining to the Resident Council. In addition, the Inspectors toured resident care areas in the home and observed infection control practices and medication administration, staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Falls Prevention
Infection Prevention and Control
Medication
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)**
- **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 drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On June 6, 2018, Inspector #592 reviewed the home's medication incident reports for the last quarter whereby an incident which occurred on a specific day in 2018, indicated that RN #103 had omitted to give resident # 009 a prescribe medication.

As per the home's risk management report, resident #009 was on a specific medication twice a day. On that specific day in 2018, in the morning resident #009 was not administered the prescribed medication as per the directions specified by the prescriber.

In an interview with the Administrator, the Administrator indicated that RN #103 did not follow the home's medication administration process as the drug had not been administered to the resident. [s. 131. (2)]

WN #2: 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 is reported to the resident, the resident's SDM, if any.

On June 06, 2018, RN #100 indicated to Inspector #592 that when a medication incident report occurs in the home, the registered nursing staff have to complete a medication incident form which is titled “ the risk management form” and as well a specific form which will be faxed to the Pharmacy service provider. RN #100 further indicated that the registered nursing staff have to report the incident to the resident or the Substitute Decision Maker (SDM), the pharmacy, physician and the DOC.

A review of the home's medication incident reports completed by registered nursing staff was done by Inspector #592. There was one incident identified in the report.

The report indicated that resident #009 was not administered a dose of a specific medication.

Upon a review of the resident health care records, documentation was found on the day of the incident in the resident’s progress notes by RN #104, which indicated that no physician, resident or family were notified of the incident as there was no harm to the resident.

On June 07, 2018, in an interview with RN # 104 who discovered the incident indicated that the family should have been contacted and the physician regardless if there was any actual or potential harm to the resident. The RN did not recall why the family and physician were not informed on the day of the incident.

On June 07, 2018, the Administrator indicated that upon a review of the medication incident for resident #009, that no resident/ family and physician were documented as being informed. [s. 135. (1)]

Issued on this 10th day of July, 2018

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

Original report signed by the inspector.