Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d’Ottawa
347 rue Preston bureau 420
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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
Sep 9, 2019	2019_583117_0036	015235-19	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

LYNE DUCHESNE (117)

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): August 20, 21 and 28, 2019

This inspection relates to log # 015235-19 and a critical incident report (CIS # 0925-000005-19) in which a there was a medication incident / adverse drug reaction.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), to the Nursing Coordinator, to several Registered Nurses (RNs), to several Registered Practical Nurses (RPNs), to a Personal Support Worker (PSW), to the Chief Executive Officer of Global Health Care Services Agency, as well as to several residents.

During the course of the inspector, the inspector reviewed several residents’ health care records, observed the provision of care and services including medication administration, reviewed an internal investigation report, reviewed Chartwell policy #LTC-CA-WQ-200-06-01 “Pharmacy and Therapeutics: Medication Administration”, revised December 2017 and reviewed registered nursing staff education and orientation related medication management systems as well as registered nursing staffing schedule for July and August 2019.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Medication
Sufficient Staffing
Training and Orientation

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

- **2 WN(s)**
- **0 VPC(s)**
- **2 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	Légende 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. 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 where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures 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 and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The license has a policy #LTC-CA-WQ-200-06-01 “Pharmacy and Therapeutics: Medication Administration”, revised December 2017. The policy is in line with the College of Ontario (CNO) Medication Administration Practice Standards.

The policy indicates the following is to be done when conducting medication administration:
f. Locate the resident and identify the resident by checking the resident’s Ident-a-band, and picture on the eMAR (electronic Medication Administration Record). Check name, route, dosage, time and drug.

On a specified date, RPN #006 arrived at the resident #001’s room, which is shared with resident #002. The RPN went to resident #001 and administered a specified medication.

Resident #001 does not have an order for the specified medication. RPN #006 administered by error resident #002’s medication to resident #001.

As per resident #001, RPN #006 came in the room, informed resident #001 that they had their medication. Resident #001 said that they told the RPN that they did not have any of the identified medication. Resident #001 said that RPN #006 did not ask for their name or verify their identify bracelet, worn on the left wrist. However, RPN #006 continued to proceed and administered the identified medication. Resident #001 said that they were upset at having received this medication and that this is when RRPN #006 realised that they had administered the medication to the wrong resident.

The medication error was immediately reported to RN #004. Immediate nursing and medical interventions were implemented, the resident’s health status was closely monitored, medication was administered, and the resident transferred to hospital for further assessment. (see WN #2)

RN #004 and PSW #008 who were working at the time of the incident, said that resident #001 is alert and knows which medication they receive. The resident #001 informed both RN #004 and PSW #008, shortly after the incident, that RPN #006 had administered the medication even when resident #001 had indicated that they did not have the identified medication. RN #004 and PSW #008 both said that resident #001 had their identification bracelet in place as well as their name and picture both in the resident room and eMAR. They also said that resident #002, who resides in the same room and who was present in the room at the time of the incident, told them that RPN #006 had entered the room, informed resident #001 that they had a specified medication for the resident and administered the medication without verifying resident #001’s identity. Resident #002 reported that RPN #006 had administered their prescribed medication to resident #001.

The home’s DOC said that RPN #006 had not followed the home’s medication administration policy and practice standards when the RPN did not verify the resident’s identity and medication prior to administering the specified medication to the wrong resident. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #2: 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 is used by or administered to a resident in the home unless unless the drug has been prescribed for the resident.

On a specified date, the resident #001 was administered an identified medication by RPN # 006. Resident #001 does not have an order for the identified medication.

RPN #006 immediately reported the medication error to RN #004. Resident #001’s physician was notified; medical orders were received to monitor the resident’s health status every 15 minutes and if there were changes in the resident’s health status a specific medication was to be administered. The resident was monitored, the resident presented with signs and symptoms of an adverse medication reaction and the specific medication was administered. The resident was transferred to hospital for further assessment. The resident later returned to the long-term care home.

As such, resident #001 was administered a medication that was not prescribed for the resident on a specified date in 2019. [s. 131. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

Issued on this 11th day of September, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l’inspecteur (No) : LYNE DUCHESNE (117)

Inspection No. / No de l’inspection : 2019_583117_0036

Log No. / No de registre : 015235-19

Type of Inspection / Genre d’inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Sep 9, 2019

Licensee / Titulaire de permis : Chartwell Master Care LP
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD : Chartwell Champlain Long Term Care Residence
428 Front Road West, L'Orignal, ON, K0B-1K0

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Dany Roussel

To Chartwell Master Care LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s.8 (1) b.

Specifically, the licensee shall ensure that their policy #LTC-CA-WQ-200-06-01 "Pharmacy and Therapeutics: Medication Administration", revised December 2017, related to an interdisciplinary medication management system that provides safe medication management system and optimizes effective drug therapy outcomes for residents is complied with.

In order to ensure compliance with the medication management system, medication administration policy, the licensee shall develop and implement monitoring and remedial processes:

A) At a minimum, adherence to the policy and procedures to ensure that medications , including a specific medication, are administered to resident #001 and resident #002 as prescribed, and any other resident who is prescribed a specific medication, shall be measured on a weekly basis on all units for a period of 4 consecutive weeks.
B) The licensee shall ensure that corrective action is taken if deviations from established policy #LTC-CA-WQ-200-06-01 "Pharmacy and Therapeutics: Medication Administration", revised December 2017.
C) A written record must kept of everything required under (a) and (b).

Grounds / Motifs :

1. The licensee has failed to ensure that where this Act or this Regulation requires, the licensee of a long-term care home to have put in place any policy and procedure and that the licensee is required to ensure that the policy and procedure put in place: (b) is complied with.

As per O.Reg. 114 Medication Management Systems, the licensee is to have developed an interdisciplinary medication management system that provides safe medication management, that the licensee ensures 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 and that the written policies and protocols be implemented, in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The license has a policy #LTC-CA-WQ-200-06-01 "Pharmacy and Therapeutics: Medication Administration", revised December 2017. The policy is in line with the College of Ontario (CNO) Medication Administration Practice Standards.

The policy indicates the following is to be done when conducting medication administration:
f. Locate the resident and identify the resident by checking the resident's Ident-a-band, and picture on the eMAR (electronic Medication Administration Record). Check name, route, dosage, time and drug.

On a specified date, RPN #006 arrived at the resident #001's room, which is shared with resident #002. The RPN went to resident #001 and administered a specified medication. Resident #001 does not have an order for the specified medication. RPN #006 administered by error resident #002's medication to resident #001.

As per resident #001, RPN #006 came in the room, informed resident #001 that they had their medication. Resident #001 said that they told the RPN that they did not have any of the identified medication. Resident #001 said that RPN #006 did not ask for their name or verify their identify bracelet, worn on the left wrist. However, RPN #006 continued to proceed and administered the identified medication. Resident #001 said that they were upset at having received this medication and that this is when RRPN #006 realised that they had

administered the medication to the wrong resident.

The medication error was immediately reported to RN #004. Immediate nursing and medical interventions were implemented, the resident’s health status was closely monitored, medication was administered, and the resident transferred to hospital for further assessment. (see WN #2)

RN #004 and PSW #008 who were working at the time of the incident, said that resident #001 is alert and knows which medication they receive. The resident #001 informed both RN #004 and PSW #008, shortly after the incident, that RPN #006 had administered the medication even when resident #001 had indicated that they did not have the identified medication. RN #004 and PSW #008 both said that resident #001 had their identification bracelet in place as well as their name and picture both in the resident room and eMAR. They also said that resident #002, who resides in the same room and who was present in the room at the time of the incident, told them that RPN #006 had entered the room, informed resident #001 that they had a specified medication for the resident and administered the medication without verifying resident #001’s identity. Resident #002 reported that RPN #006 had administered their prescribed medication to resident #001.

The home’s DOC said that RPN #006 had not followed the home’s medication administration policy and practice standards when the RPN did not verify the resident’s identity and medication prior to administering the specified medication to the wrong resident.

The severity of this issue was determined to be a level 3 as there was actual harm. Medications are identified as a Key Risk Indicator.
The scope was a level 1 as this was an isolated incident. The home had a level 0 of Compliance History, with no previous compliance issues.

(117)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2019

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s.131 (1).

Specifically, the licensee shall ensure that no drugs are administered to resident #001, and other resident, unless the drug has been prescribed for the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless unless the drug has been prescribed for the resident.

On a specified date, the resident #001 was administered an identified medication by RPN # 006. Resident #001 does not have an order for the identified medication.

RPN #006 immediately reported the medication error to RN #004. Resident #001’s physician was notified; medical orders were received to monitor the resident’s health status every 15 minutes and if there were changes in the resident’s health status a specific medication was to be administered. The resident was monitored, the resident presented with signs and symptoms of an adverse medication reaction and the specific medication was administered. The resident was transferred to hospital for further assessment. The resident later returned to the long-term care home.

As such, resident #001 was administered a medication that was not prescribed for the resident on a specified date in 2019.

The severity of this issue was determined to be a level 3 as there was actual harm. Medications are identified as a Key Risk Indicator.
The scope was a level 1 as this was an isolated incident. The home had a level 3 Compliance History, with previous non-compliance in the same subsection.

- O.Reg. s 131 (2): issued as a WN on June 4, 2018 under inspection # 2018_683126_0011
- O.Reg. s 131 (2): issued as a WN on June 8, 2017 under inspection # 2017_671126_0008 (117)

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l’article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l’ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l’ordre qui font l’objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l’adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 9th day of September, 2019

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : LYNE DUCHESNE

Service Area Office / Bureau régional de services : Ottawa Service Area Office